CURATIVE HEALTH SERVICES INC
Form 10-K
April 11, 2006

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

ý	**Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2005

OR

o	**Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

Commission File Number: 000-50371

Curative Health Services, Inc.

(Exact name of registrant as specified in its charter)

MINNESOTA	**51-0467366**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

61 Spit Brook Road

Nashua, New Hampshire 03060

(Address of principal executive offices)

(603) 888-1500

(Registrant s telephone number, including area code)

Internet Website: **http://www.curative.com**

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

None

Securities registered pursuant to section 12(g) of the Act:

Common Stock, par value $.01 per share

(Title of Class)

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

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 o No ý

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 ý No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of 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. ý

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer (as defined in Rule 12b-2 of the Exchange Act):

Large accelerated filer o Accelerated filer o Non-accelerated filer ý

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act. Yes o No ý

The aggregate market value of voting stock held by non-affiliates of the registrant, as of June 30, 2005, was approximately $22.4 million (based on the last sale price of such stock as reported by the Nasdaq National Market).

As of March 1, 2006, there were 13,043,133 shares of the Registrant s Common Stock, $.01 par value, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this Form 10-K is incorporated by reference to portions of our definitive proxy statement for our 2006 Annual Meeting of Shareholders to be filed with the Securities and Exchange Commission on or before April 30, 2006.

PART I

In this Annual Report on Form 10-K, unless the context requires otherwise, Curative, Company, we, our, and us refer collectively to Curativ Health Services, Inc. and its consolidated subsidiaries

FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements within the meaning of section 27A of the Securities Act and section 21C of the Securities Exchange Act of 1934, as amended, including statements concerning possible or assumed future results of operations of the Company and those preceded by, followed by, or that include the word may, will, should, could, expects, plans, anticipates, believes, predicts, potential, or continue or the negative of such terms and other comparable terminology. These statements are only predictions. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. You should understand that the factors described below, in addition to those discussed under Item 1A, Risk Factors, and elsewhere in this Annual Report on Form 10-K, could materially affect our future results and could cause those results to differ materially from those expressed in such forward looking statements. These factors include:

material adverse changes in economic conditions in the markets we serve;

uncertainties with respect to the bankruptcy process and confirmation of our Prepackaged Joint Plan of Reorganization (see Planned Reorganization and Chapter 11 Bankruptcy Proceedings below);

increases in labor costs;

potential difficulties in attracting and retaining quality management and key personnel to execute the our current business strategy;

failure to obtain new customers or retain existing customers;

issues related to our financial situation and liquidity needs;

inability to carry out our business strategies;

changes in reimbursement policies and other legislative or regulatory initiatives aimed at reducing costs associated with the Medicaid and Medicare programs;

integration risks in connection with our multiple acquisitions;

relationships with a limited number of biopharmaceutical and pharmaceutical suppliers;

relationships with our key community-based representatives;

relationships with our payors;

relationships with our shippers;

the competitive nature of our business;

changes in the extensive government regulations to which we are subject;

our substantial indebtedness;

our ability to generate sufficient cash;

the ultimate resolution of litigation and indemnification claims against us; and

other risks and uncertainties as may be detailed from time to time in our public announcements and SEC filings.

Except as required by law, we are under no obligation to update any forward-looking statement, whether as a result of new information, future events or otherwise. Forward-looking statements are provided in this Annual Report on Form 10-K pursuant to the safe harbor established under the Private Securities Litigation Reform Act of 1995 and should be evaluated in the context of the estimates, assumptions, uncertainties, and risks described herein.

ITEM 1. BUSINESS

OVERVIEW

Curative Health Services, Inc. operates a Specialty Infusion business unit and a Wound Care Management business unit to deliver high-quality care and positive clinical outcomes for patients experiencing serious acute or chronic medical conditions.

Our Specialty Infusion business unit provides intravenous and injectable biopharmaceutical and compounded pharmaceutical products and comprehensive infusion services to patients with chronic and critical disease states. All patient care is delivered through a national footprint of community-based branches. Each local branch has an experienced multidisciplinary team of pharmacists, nurses, reimbursement specialists and patient service representatives who comprehensively manage all aspects of a patient s infusion and related support needs. We purchase biopharmaceutical and other pharmaceutical products from suppliers and contract with insurance companies and other payors to provide our services, which include coordination of patient care, 24-hour nursing and pharmacy availability, patient education and reimbursement billing and collection services. The products distributed and the injection or infusion therapies offered by Curative are used by patients with chronic or severe conditions such as hemophilia, immune system disorders, chronic or severe infections, nutritionally compromised and other severe conditions requiring nutritional support, cancer, rheumatoid arthritis, hepatitis C and multiple sclerosis. Examples of biopharmaceutical products used by Curative s patients include hemophilia clotting factor, intravenous immune globulins (IVIG) and Remicade®. Examples of pharmaceutical products used by Curative s patients include compounded pharmaceuticals, such as total parenteral nutrition (TPN) products, anti-infectives, chemotherapy agents and pain management products. As of December 31, 2005, we had approximately 485 payor contracts and provided products or services in approximately 45 states.

Our Wound Care Management business unit is a leading provider of wound care services specializing in chronic wound care management. It manages, on behalf of hospital clients, a nationwide network of Wound Care Center® programs that offer a comprehensive range of services across a continuum of care for treatment of chronic wounds. Our Wound Management Program℠ consists of diagnostic and therapeutic treatment procedures that are designed to meet each patient s specific wound care needs on a cost-effective basis. Our treatment procedures are designed to achieve positive results for wound healing based on significant experience in the field. We maintain a proprietary database of patient results that we have collected since 1988 containing over 534,000 patient cases. Our treatment procedures, which are based on extensive patient data, have allowed us to achieve an overall rate of healing of approximately 89% at December 31, 2005 for patients completing

therapy. As of December 31, 2005, our Wound Care Center® network consisted of 109 outpatient clinics (103 operating and 6 contracted) located on or near campuses of acute care hospitals in approximately 30 states.

Our predecessor was incorporated in the State of Minnesota in 1984 under the name Curatech, Inc. It changed its name to Curative Technologies, Inc. in March 1990 and to Curative Health Services, Inc. in June 1996. In August 2003, our predecessor effected a holding company reorganization in which we became the holding company of our predecessor, which is now the direct parent of all of our other current subsidiaries, except for Curative Health Services of New York, Inc. and Critical Care Systems, Inc. which are our direct subsidiaries. We assumed the name Curative Health Services, Inc. and our predecessor changed its name to Curative Health Services Co. Our principal executive offices are currently located at 61 Spit Brook Road, Nashua, New Hampshire 03060, telephone number (603) 888-1500.

PLANNED REORGANIZATION AND CHAPTER 11 BANKRUPTCY PROCEEDINGS

On March 27, 2006, Curative and each of its direct and indirect subsidiaries filed voluntary petitions under chapter 11 of title 11 of the United States Code (the Bankruptcy Code) in the United States Bankruptcy Court for the Southern District of New York (the Bankruptcy Court). We filed our chapter 11 cases (the Chapter 11 Cases) to implement and effect our Prepackaged Joint Plan of Reorganization, dated February 6, 2006 (the Plan). Prior to commencement of the Chapter 11 Cases, we solicited votes to accept or reject the Plan from the holders of the $185.0 million aggregate principal amount of 10.75% senior notes due 2011 (the Senior Notes) issued by Curative and the holders of known general unsecured claims against the Company as of February 6, 2006. Prior to the commencement of the Chapter 11 Cases, the Company received the requisite votes for the Plan to be confirmable under Section 1129 of the Bankruptcy Code.

The Plan was filed with the Bankruptcy Court on March 27, 2006. The Plan, which is described in more detail below, will, if confirmed and consummated, result in the cancellation and discharge of all claims relating to the Senior Notes. Each holder of Senior Notes (each, a Senior Noteholder) will receive a cash payment of approximately 54.9% of its respective claim related to the Senior Notes, unless a Senior Noteholder was qualified to elect and did elect to receive its pro rata share of certain cash consideration provided in the Plan and the common stock of reorganized Curative (the New Curative Common Stock). Holders of existing shares of Curative common stock (Old Curative Common Stock) and options will not receive any distributions under the Plan and all shares of Old Curative Common Stock and options will be extinguished.

In connection with the reorganization to be effected by the Plan, we intend to deregister our existing securities under the Securities Exchange Act of 1934, and become a private company upon our emergence from Chapter 11.

Events Leading to Chapter 11 Cases

Factors Affecting our Liquidity

Since June 2004, we have faced various issues that have negatively affected our liquidity and our ability to service our debt obligations. Specifically, and as described in further detail below, we have experienced reduced revenue generation as a result of:

California s modification of its blood-product reimbursement methodology,

a modification of the federal government s blood-product reimbursement methodology,

slow maturation of certain new branch locations,

the resignation of certain customer sales and service representatives, and

additional future liquidity risks, including potential indemnification claims.

Significant Decrease in Blood-Product Reimbursement

On April 23, 2004, we acquired Critical Care Systems, Inc. (CCS), a leading national provider of specialty infusion pharmaceuticals and related services for a purchase price of $154.2 million, including working capital adjustments of approximately $4.1 million. The acquisition of CCS was financed with a portion of the proceeds obtained from the issuance of the Senior Notes and additional borrowings.

At the time of the CCS acquisition, a significant portion of the Company s business involved the sale of blood-clotting products by us to hemophilia patients who are beneficiaries of California s Medicaid (Medi-Cal) program or other state funded programs for hemophilia patients. These blood products were dispensed directly to patients or through our relationships with third party pharmacies.

In May 2004, California announced that, effective June 1, 2004, California modified its reimbursement methodology for blood-clotting products to average selling price (ASP) (as provided by the manufacturer) plus 20%. This change in California s reimbursement methodology amounted to an approximate 30-40% reduction from the acquisition cost plus 1% methodology previously in effect. The implementation of this reduction in

reimbursement from Medi-Cal, and changes in regulations governing such reimbursement, significantly impacted the Company s revenues from the sale of blood-clotting products.

In addition to the 30%-40% decrease in revenue for blood-clotting products generated from Medi-Cal reimbursement, in November 2004, the federal government announced that, effective January 1, 2005, it would modify its reimbursement methodology for blood-clotting products in a manner which would negatively affect our revenues. Prior to January 1, 2005, we were able to seek reimbursement from Medicare for blood-clotting products at a rate of 95% of the average wholesale price (AWP). After January 1, 2005, Medicare reimbursed for blood-clotting products at a rate of ASP plus 6% plus a $0.14 per unit dispensing fee.

Underperforming Branch Expansion

Our overall growth strategy, and our approach to offsetting the decreased revenue resulting from the change in Medi-Cal reimbursement methodology described above, included opening 13 new branches throughout the United States since June 2004. We projected that these new branches would quickly enter into the necessary service contracts and other business and patient relationships in the short-term and begin generating positive revenue consistent with historical results. However, for various reasons, including slower than anticipated managed care contract signings, certain of these branches have not matured as quickly as planned and have not generated anticipated revenues.

Resignation of Hemophilia Service Representatives

The success of our Specialty Infusion business unit depends in part upon our ability to retain key employees, referred to as hemophilia services representatives, who service hemophilia patients. The hemophilia service representatives are the chief contacts and maintain the primary relationship with our customers. While we have employment agreements with our hemophilia service representatives which, where appropriate, contain covenants not to compete and other restrictive covenants that apply if the hemophilia service representatives cease employment with us, the loss of any hemophilia service representatives could result in the loss of a significant number of customers and corresponding revenue from the sale of blood-clotting products to such customers.

On October 21, 2005, six hemophilia service representatives resigned. We estimate that the patients serviced by these employees represent approximately $25.0 million of revenue annually. While it is not certain that we will lose the full $25.0 million of revenue, it is likely that we will experience a significant decrease in revenue as a result of these resignations. We may experience the loss of other hemophilia services representatives in the future which could adversely affect our business and prospects.

In addition to the factors adversely affecting our revenue generation described above, our future liquidity may also be affected by the following additional factor:

The Pharmacy Claims. Two of our subsidiaries, Apex Therapeutic Care, Inc. (Apex) and eBioCare.com, Inc. (eBioCare), might be subject to potential indemnification liabilities to three independent retail pharmacies that previously did business with us. The indemnification claims are in connection with an audit conducted by the Department of Health Services of the State of California (the DHS Audit) related to the pharmacies medical billing for

clotting factor supplied to the pharmacies by Apex and eBioCare, and the pharmacies medical billing for the anti-inhibitor product FEIBA supplied to the pharmacies by Apex and eBioCare. While liability with respect to these claims is uncertain at this time, Apex and eBioCare believe that some amount of monetary loss is reasonably possible if the pharmacies assert and prevail on indemnification claims. Apex and eBioCare estimate that the range of loss may be anywhere from $0 to $39.3 million.

Plan Negotiations and Solicitation of Votes on the Prepackaged Plan

As a result of the foregoing factors, in June 2005, we began evaluating strategic alternatives and subsequently retained UBS Securities LLC as our financial advisors. In September 2005, certain holders of our Senior Notes formed an Ad Hoc Committee and we began discussions with them with respect to a de-leveraging of our balance sheet. On November 1, 2005, we were required to make an interest payment in the amount of approximately $9.9 million to the Senior Noteholders. We elected not to make this interest payment and to use the 30-day grace period available under the indenture. Upon expiration of the grace period on November 30, 2005, we did not make the

interest payment and an event of default occurred under the Senior Notes, which also triggered an event of default under our prepetition credit facility (the Existing Credit Facility) with General Electric Capital Corporation (GECC).

In connection with the Existing Credit Facility, on December 1, 2005, we entered into a Forbearance Agreement, as amended (Forbearance Agreement) with GECC. The Forbearance Agreement provides that, subject to certain conditions, GECC, together with the other lenders under the Existing Credit Facility, which is governed by a Credit Agreement dated April 23, 2004, as amended (the Credit Agreement), will forbear from exercising remedies on account of the cross-default under the Credit Agreement arising from our failure to pay interest on the Senior Notes. Subject to certain termination events, including additional events of default under the Credit Agreement, the Forbearance Agreement will expire on June 10, 2006. Under the terms of the Forbearance Agreement, we may continue to draw-down under the Credit Agreement as if such existing events of default had not occurred. Upon termination of the Forbearance Agreement, all obligations under the Credit Agreement, together with interest, will be immediately due and payable and the lenders may exercise any rights or remedies thereunder.

The Forbearance Agreement provides that interest on outstanding amounts on the revolver facility will accrue at the default rate under the agreement, but paid at the rate in the agreement as if no event of default had occurred. The difference between interest accrued and interest paid, the PIK spread, becomes due and payable at the end of the forbearance period, provided however that GECC will waive such additional interest due as long as: 1) a terminating event under the facility does not occur, 2) we accept GECC s proposal for a DIP Credit facility and 3) GECC provides the Exit Facility (see Note 1 of Notes to Consolidated Financial Statements). In addition, the Forbearance Agreement waives payment of an early termination fee that became due and payable of $1.2 million, subject to the same conditions as the PIK interest. We recorded the $1.2 million termination penalty and PIK interest in the accompanying financial statements. As of April 5, 2006, our obligations under our Existing Credit Facility with GECC have been paid in full in connection with the interim order of the Bankruptcy Court authorizing the DIP Financing described below. The DIP Financing remains subject to approval by the Bankruptcy Court on a final basis. If the Bankruptcy Court does not enter a final order approving the DIP Financing, the Existing Credit Facility will be reinstated.

On December 2, 2005, we reached an agreement with the Ad Hoc Committee on the general terms of a financial restructuring and entered into a Plan Support Agreement. The financial restructuring, as contemplated by the Plan Support Agreement and the Plan, is designed to (a) de-leverage our balance sheet, (b) provide us with substantial liquidity to conduct our business operations, (c) ensure that our business operations are unaffected by the Chapter 11 Cases and that we are able to retain our existing management and employees and (d) provide the greatest return to our creditors. Under the Plan Support Agreement, the Senior Noteholders party thereto agreed to forbear from exercising remedies with respect to any defaults and events of defaults arising, or that may arise, under the Senior Notes, and agreed further to take all commercially reasonable actions to oppose and object to, and not to support, any person s taking action to exercise remedies with respect to the Senior Notes. The Plan Support Agreement will terminate on July 31, 2006, or upon the earlier failure to satisfy certain milestones with respect to the Prepackaged Plan.

On February 6, 2006, pursuant to the Plan Support Agreement, we commenced solicitation of votes on the Prepackaged Plan. In connection with the solicitation, we circulated the Disclosure Statement in support of the Prepackaged Plan (the Disclosure Statement) to the Senior Noteholders and the holders of known general unsecured claims against the Company as of February 6, 2006.

The solicitation period with respect to votes on the Plan ended on March 13, 2006. The Plan was accepted by 93.2% in number and 99.7% in amount of the beneficial holders of the Senior Noteholders voting on the Plan. Holders of general unsecured claims against Curative and its subsidiaries, excluding Apex and eBioCare, (the Curative Debtors) voted to accept the Plan (62.5% in number and 91.1% in amount). The only classes of creditors entitled to vote on the Plan and who did not vote to accept the Plan were general unsecured claims against Apex and eBioCare.

The Plan was filed with the Bankruptcy Court on March 27, 2006, along with the Disclosure Statement, our chapter 11 petition, the chapter 11 petitions for each of our subsidiaries, and various motions and applications requesting relief from the Bankruptcy Court to facilitate the administration of our Chapter 11 Cases.

On February 21, 2006, Curative s existing common stock was delisted from the NASDAQ National Market System, due to Curative s continuing failure to satisfy the continued listing requirements of that market. Since that date, Curative s existing common stock has traded in the over-the-counter market.

General Structure of the Plan

Under the Plan, we have established three groups of classes of claims: (i) claims against the Curative Debtors, (ii) claims against Apex and (iii) claims against eBioCare. The Plan achieves a consensual de-leveraging of our balance sheet and ensures that we will be a private company upon emergence from bankruptcy. The Plan includes, among other things, the following key terms:

Old Curative Common Stock. On the date the Plan becomes effective, all shares of Old Curative Common Stock and options will be cancelled and Curative s obligation to file reports and other information under the Securities Exchange Act of 1934, such as Forms 10-K and 10-Q, will be terminated. The sole equity interests in reorganized Curative will consist of the New Curative Common Stock. Holders of Old Curative Common Stock and options will not receive any distributions pursuant to the Plan.

Senior Notes. Pursuant to the elections made under the Plan, eligible Senior Noteholders representing approximately 88% in aggregate principal amount of Senior Notes, or $162.9, will receive their respective pro rata shares of cash consideration and shares of New Curative Common Stock on the effective date of the Plan. The remaining Senior Noteholders will receive cash in an aggregate amount as provided in the Plan in exchange for their claims and will not receive any shares of New Curative Common Stock.

Rights Offering. Prior to solicitation of votes on the Plan, we issued non-certificated subscription rights to certain members of the Ad Hoc Committee entitling them to purchase shares of New Curative Common Stock on the effective date of the Plan. Pursuant to Election and Subscription Agreements, the members of the Ad Hoc Committee have agreed to exercise their rights on the Plan s effective date. The proceeds from the exercise of the rights will be used to fund a substantial majority of the cash distributions under the Plan to those holders of Senior Notes who will not receive New Curative Common Stock.

Treatment of General Unsecured Claims. Each holder of an undisputed general unsecured claim against the Company (other than those against Apex and eBioCare) will receive a promissory note in a face amount equal to approximately 56% of its respective claim. Each holder of an undisputed general unsecured claim against each of Apex and eBioCare will receive a promissory note in a face amount equal to approximately 5.2% of its respective claim. Prior to the commencement of the Chapter 11 Cases, each holder of a general unsecured claim against each of the Curative Debtors, Apex and eBioCare had the option to elect to receive a cash payment in an amount equal to 50% of the face amount of its respective promissory note. No such holder exercised the cash option. In accordance with certain orders entered by the Bankruptcy Court and the Plan, certain general unsecured claims will be unimpaired and paid in full.

Existing Credit Facility. As of April 5, 2006, our obligations under our Existing Credit Facility with GECC have been paid in full in connection with the interim order of the Bankruptcy Court authorizing the debtor-in-possession financing facility described below. The DIP Financing remains subject to approval by the Bankruptcy Court on a final

basis. If the Bankruptcy Court does not enter a final order approving the DIP Financing, the Existing Credit Facility will be reinstated.

Other Secured Claims. Secured claims against the Company (other than the claims relating to the Existing Credit Facility) will be unimpaired.

Debtor-in-Possession Financing. The Bankruptcy Court entered an interim order authorizing the Company to enter into a $45.0 million debtor-in-possession credit facility that is secured by all or substantially all of our assets and a pledge of the equity interests of each of our subsidiaries (the DIP Financing). Subject to approval by the Bankruptcy Court on a final basis, he proceeds of the DIP Financing were used to pay, in full, all amounts outstanding under our Existing Credit Facility as of April 5, 2006 and also will be used for working capital and other general corporate purposes during the Chapter 11 Cases.

The DIP Financing provides for a secured revolving credit facility of up to $45.0 million, of which we can use up to $7.5 million as a letter of credit sub facility and up to $5.0 million as a swingline sub facility (i.e., a short-term loan advance facility). We used the facility immediately to pay all of our outstanding borrowings under the previous facility.

We will pay all accrued interest on outstanding LIBOR loans on the last day of the applicable LIBOR period, provided in the case of any LIBOR period greater than three months in duration, interest shall be payable at three month intervals and on the last day of such LIBOR period. All accrued interest on

outstanding revolving credit LIBOR loan advances will bear interest at an annual rate equal to the LIBOR rate plus an additional amount based on our senior leverage ratio, which additional amounts may range from 3% to 3.5%. For outstanding base rate loans, we will pay all accrued interest on the first business day of each calendar quarter. All accrued interest on outstanding revolving credit base rate loans bears interest at an annual rate equal to the base rate plus an additional amount based on our senior leverage ratio, which additional amounts may range from 1.75% to 2.25% for the revolving credit base rate loans.

Pursuant to the terms of the credit agreement governing the DIP Financing, (the DIP Credit Agreement), we have made certain representations and warranties to GECC and are subject to certain reporting requirements and financial and other covenants. The credit facility restricts our ability to incur or to permit any of our properties or assets to be encumbered by liens. The credit facility also restricts our ability to make certain types of payments relating to our capital stock, including the declaration or payment of dividends. Consolidations, mergers, sales of assets and the creation of additional subsidiaries are also restricted, as is our ability to purchase assets and to make investments. The covenants also restrict transactions with our affiliates and require us to maintain certain levels with respect to our total leverage ratio, senior leverage ratio and fixed charge coverage ratio. The DIP facility provided for conditions to close which included covenants related to levels of our fixed charges coverage ratio, senior secured leverage ratio and total leverage ratio. We were in compliance with these as well as other requirements as of the close date.

New Management Incentive Plan. Upon emergence from Chapter 11, we will adopt a new management incentive plan that is intended to provide incentives after the effective date to certain employees to continue their efforts to foster and promote the long-term growth and performance of our businesses.

Certificate of Incorporation and By-laws of reorganized Curative. Pursuant to the Plan, reorganized Curative will adopt a revised certificate of incorporation and by-laws which will be substantially in the form set forth in the Plan Supplement (as filed on Form 8-K on March 7, 2006, and as the same may be revised in accordance with the Plan). The form of by-laws includes provisions requiring the affirmative vote of 62.5% of the outstanding New Curative Common Stock to effect: (i) any merger or consolidation in which reorganized Curative is a constituent corporation, (ii) a sale of all or substantially all of the assets of reorganized Curative, (iii) any amendment of the certificate of incorporation or bylaws of reorganized Curative, (iv) any issuance of greater than 20% of the New Curative Common Stock then outstanding or (v) any agreement between reorganized Curative or any subsidiary of reorganized Curative and any of its affiliates (subject to certain exceptions, including for contracts in the ordinary course of reorganized Curative s business). The form of by-laws also includes certain supermajority voting requirements for the board of directors of reorganized Curative that will be required for the issuance of senior equity securities or the incurrence of indebtedness above certain levels. The form of certificate of incorporation also provides that stockholders will have preemption rights in respect of future issuances of New Curative Common Stock.

Stockholders Agreement and Registration Rights Agreement of Reorganized Curative. Pursuant to the Plan, all persons receiving New Curative Common Stock will execute a joinder to the Stockholders Agreement, and persons receiving 5% or more of the New Curative Common Stock will execute a joinder to the Registration Rights Agreement. The Stockholders Agreement and the Registration Rights Agreement will be substantially in the form set forth in the Plan Supplement (as filed on Form 8-K on March 7, 2006, and as the same may be revised in accordance with the Plan). The form of Stockholders Agreement prevents a party to the agreement from selling any of its shares to a person if, as a result of such sale, the purchaser would own more than 62.5% of the New Curative Common Stock then outstanding unless the purchaser agrees to purchase all shares of New Curative Common Stock held by any party to the Stockholders Agreement who wishes to sell its shares, at the highest price paid by the purchaser for any shares

of Curative common stock acquired during the preceding 18 months. The form of Stockholders Agreement also provides that parties to the agreement shall vote to elect two directors to the board of directors of reorganized Curative who are nominated by any person or group owning 33.3% or more of the New Curative Common Stock and one director who is nominated by any person owing more than 16.7% of the New Curative Common Stock but less than 33.3%. The form of Registration Rights Agreement provides that registration rights holders holding at least a majority of the outstanding shares of New Curative Common Stock will have the right to require reorganized Curative to register an initial public offering that includes (a) shares to be sold by such stockholders after the second anniversary of the effective date of the Plan and (b) registration rights holders beneficially owning at least 25% of the

outstanding shares of New Curative Common Stock will have the right to require such an initial public offering on or after the date that is 42 months following the Effective Date of the Plan. The form of Registration Rights Agreement also provides for certain demand and piggy back registration rights following an initial registered public offering until the seventh anniversary of the Plan s effective date.

The Plan is subject to formal approvals by the Bankruptcy Court prior to consummation. There can be no assurance that the Bankruptcy Court will approve and confirm the Plan.

SPECIALTY INFUSION BUSINESS UNIT

Our Specialty Infusion business unit provides high-cost, injectable or infusible biopharmaceutical and compounded pharmaceutical products to patients with chronic health conditions for which there is no known cure and to patients with critical disease states that require specialized expertise in high touch injectable and infusion therapies. High touch therapies require clinical management, special product handling and specialized nursing administration. Our Specialty Infusion business unit focuses on and has core strengths in several therapies, including hemophilia clotting factor, anti-infective therapy, IVIG and TPN. These products are used by patients with chronic or severe conditions such as hemophilia, RSV, immune system disorders, chronic or severe infections, nutritionally compromised and other severe conditions requiring nutritional support, cancer, rheumatoid arthritis, hepatitis C and multiple sclerosis. Our local pharmacies provide biopharmaceutical and compounded pharmaceutical products which are generally injected or administered intravenously to patients in their homes and other alternative locations by a team of clinical professionals. We also provide patient education and instruction regarding the administration of medications, clinical supervision of patient compliance, specialized delivery services, including refrigerated delivery and expedited overnight mail or courier service, patient and community advocacy and reimbursement services for or on behalf of patients and payors. Additionally, we provide intravenous infusion services to patients in their home by an experienced team of clinical professionals or in our ambulatory infusion suites located in some of our branch pharmacies.

Our Specialty Infusion business unit purchases biopharmaceutical and other pharmaceutical products from suppliers and manufacturers and contracts with insurance companies and other payors, including managed care organizations, Medicare and Medicaid programs, to provide clinical management and related injectable and infusible services. Specialty Infusion revenues are derived primarily from fees paid by the payors for the distribution of these biopharmaceutical and other pharmaceutical products and for the injection or infusion services provided. Additional revenues are acquired through biopharmaceutical and pharmaceutical product distribution and support services under contracts with retail pharmacies for which we receive related service fees.

Prior to December 2, 2005, our Specialty Infusion business unit offered Synagis® through injections to patients infected with respiratory syncytial virus, or RSV. On December 2, 2005, we sold to ProCare Pharmacy Inc. and ProCare Pharmacy Direct, Inc. (collectively, ProCare) for $1.75 million in cash certain personal property, licenses, permits, contracts, leases and patient files related to our specialty injectable and oral medications business, including Synagis®. In addition, ProCare assumed all liabilities and obligations related to the operation of the specialty injectable and oral medications business and the purchased assets arising after the consummation of the sale. We agreed not to engage in the business of providing Synagis® in any territory covered by the purchased assets for three years after the closing. See Note 5 of Notes to Consolidation Financial Statements included elsewhere in this Annual Report on Form 10-K for additional information regarding this sale.

Financial information with respect to the Specialty Infusion business unit, including information concerning revenues, operating (loss) profit from continuing operations and total assets may be found under Management s Discussion and Analysis of Financial Condition and Results of Operations and in Note 17 of Notes to Consolidated Financial Statements included elsewhere in this Annual Report on Form 10-K.

Specialty Infusion - Disease Markets and Products

As a specialty infusion company, we focus on high-margin infused therapies that require complex clinical management. The specialty infusion industry, which is a hybrid of the specialty pharmacy and traditional home infusion industries, has evolved as the approval and demand of new biopharmaceutical and pharmaceutical products has expanded. These specialty products are expensive, require temperature-sensitive storage and delivery, patient education, training and monitoring of their proper use and require the patient to inject or infuse the product.

Intravenously administered therapies tend to be more complex and potent than oral or injectable drugs. Our core services require patient training, specialized equipment and clinical monitoring by a team of pharmacists, nurses, dietitians and support staff. Our specialty infusion offering differentiates itself by specializing in complex therapies delivered by a local team of clinicians and support staff who provide a continuum of care focused on patient satisfaction, cost savings and positive clinical outcomes.

For the year ended December 31, 2005, the Specialty Infusion business unit recorded the majority of its revenues from three disease states: hemophilia (approximately 38%) for which we provide both factor VIII and factor IX blood-clotting products, immune system disorders (approximately 10%) which are typically treated with IVIG and infectious diseases (approximately 17%) for which we provide antibiotics. Additional information with respect to the Specialty Infusion business unit s revenues from disease states may be found under Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this Annual Report on Form 10-K. An overview of the disease states we service and products we offer follows.

Hemophilia. Hemophilia is a genetically inherited and currently incurable bleeding disorder resulting from a deficiency in the bloodstream of a plasma protein, called factor, which helps the blood to clot. This blood-clotting factor is essential in helping to cease the bleeding after a cut or injury and preventing spontaneous bleeding. There are two types of hemophilia: hemophilia A and hemophilia B. Hemophilia A, which represents approximately 80% of the hemophiliac population, is the result of a deficiency of factor VIII, while hemophilia B is the result of a deficiency of factor IX. The greater the deficiency of these plasma proteins, the greater the severity of the disease, measured as mild, moderate or severe.

It is estimated that there are approximately 18,000 persons, predominantly male, in the United States that suffer from hemophilia and that about seven out of ten suffer from a severe form of the disease. Treatment of hemophilia involves intravenously infusing the missing clotting factor in order to replace deficient proteins. The two types of clotting factor available are non-recombinant, made from human blood plasma, and recombinant which is laboratory produced. Patients with severe hemophilia may require multiple injections of clotting factor per week. Patients with less severe forms of hemophilia may only require clotting factor treatment after bleeding starts or before participating in an activity having a high risk of injury. Our Specialty Infusion business unit provides hemophilia patients with both factor VIII and factor IX blood-clotting products under prescription from a physician.

Infectious diseases. Anti-infective therapy involves the infusion of antibiotic, antiviral and antifungal medications for the treatment of a variety of infections, such as osteomyelitis (bone infections), bacterial endocarditis (infection of the heart valves), wound infections, infections associated with HIV/AIDS, cancer and post-kidney transplant treatment protocols. Anti-infective drugs are more effective when infused directly into the patient s blood as compared to oral ingestion. Once discharged from a hospital, a vast majority of patients utilizing the anti-infective therapy require daily treatment for approximately three to four weeks. Our Specialty Infusion business unit, in addition to offering a full range of pharmaceutical services, also offers nurse visitations to the patient s home to educate, train and monitor the patient.

Immune system disorders. The immune system acts as a natural defense system that recognizes foreign substances, such as bacteria and viruses, as being different from the body s own tissues. A healthy immune system allows the body to fight off infections while an unhealthy immune system, or immune system disorder, reduces the body s ability to fight off infections. Some immune disorders occur when the body treats its own tissues and cells as if they were foreign, prompting the immune system to produce antibodies that destroy those tissues and cells. Most of these disorders are progressive in nature and, therefore, cannot be cured. Treatment of immune disorders typically consists of intravenous infusion of immune globulins which are concentrated levels of antibodies derived from pooled human plasma designed to strengthen the immune system. Clinical oversight is generally necessary for injecting immune globulins due to the high toxicity level, length of treatment and the potential for a negative reaction to the infusion. Our Specialty Infusion business unit operates ambulatory infusion suites in some of its branch pharmacies and offers nurse visitation to the home to administer infusions to the patient there.

Nutritional Support. Certain diseases, such as inflammatory bowel disease, short bowel syndrome, pancreatitis or other gastrointestinal illnesses that prohibit oral digestion, require the patient to obtain life-sustaining nutrients through infusion. TPN is a solution that contains one or more of the following: amino acids, dextrose, fatty acids, electrolytes, trace elements, minerals and vitamins. Accordingly, TPN is mixed for each patient specifically and requires a high

degree of pharmacy manipulation. TPN therapy is also utilized to augment the nutritional status of patients with cancer, hyperemesis and eating disorders. Certain patients require TPN for life, while others may only need short-term therapy. Our Specialty Infusion business unit offers nutritional assessments, clinical pharmacy consultants, nurse visitations to the patient s home, patient education, blood draws and patient monitoring.

Cancer. Chemotherapy, the use of drugs to treat cancer, works by seeking out and destroying fast-growing cells. However, chemotherapy not only attacks cancer cells, but also healthy cells which are needed for strength. One of the common side effects of chemotherapy, and the most prevalent, is anemia which occurs when the body does not have enough red blood cells. Red blood cells carry hemoglobin, which transports oxygen to cells and organs. Once depleted of red blood cells, the body is then unable to adequately transport oxygen and fatigue results, stealing the physical and emotional strength needed to fight cancer. Anemia affects up to two out of three chemotherapy patients. Another side effect of chemotherapy is a severe drop in infection-fighting white blood cells, a condition called neutropenia. About half of cancer chemotherapy patients develop neutropenia, placing them at risk for life-threatening infections which may require hospitalization and can delay chemotherapy treatment and reduce its effectiveness. Our Specialty Infusion business unit provides chemotherapeutic regimens for cancer treatments, anti-infective therapy for infections associated with cancer treatments, TPN for nutritionally compromised cancer patients and other adjunctive chemotherapy treatments, such as Epogen®, Procrit® and Neupogen® to treat red and white blood cell deficiencies.

Rheumatoid arthritis. Rheumatoid arthritis is a chronic inflammatory disease of the synovium, or lining of the joint, that results in pain, stiffness, swelling, deformity and loss of function in the joints as cartilage and bone is destroyed. This inflammation is most common in the hands and the feet. It is estimated that approximately 2.1 million people in the United States, or 1% of the population, have rheumatoid arthritis. The treatment of rheumatoid arthritis involves specialty biopharmaceuticals and pharmaceuticals. Our Specialty Infusion business unit provides specialty anti-inflammatory biopharmaceuticals to treat the symptoms of rheumatoid arthritis, such as Enbrel®, generally taken several times weekly, and Remicade®, an infused therapy generally taken bi-monthly and administered in a physician s office, the patient s home or in one of our local ambulatory infusion suites.

Hepatitis C. Hepatitis C is a blood-borne infection that can attack and damage the liver. The hepatitis C virus is spread predominately through contact with infected blood and can lead to cirrhosis, liver cancer or liver failure. Hepatitis C is characterized by a consistent elevation of liver enzymes and is the principal reason for liver transplant. The virus affects an estimated four million persons in the United States; however, with proper treatment, about 40% - 80% of all patients can now be cured. Our Specialty Infusion business unit provides hepatitis C treatments such as PEG-Intron®, Rebetron® and Rebetol®.

Multiple sclerosis. Multiple sclerosis is a chronic disease of the central nervous system for which neither a cause nor a cure is currently known. The central nervous system is made up of nerves that act as the body s messenger system. Nerves are protected by substances called myelin, which insulate the nerves and aid in the transmission of nerve impulses, or messages between the brain and other parts of the body. In patients with multiple sclerosis, the body s immune cells enter the brain and spinal cord and attack the protective myelin covering. Once the myelin is gone and replaced with scar tissue, a process called demyelination, nerve impulses sent throughout the central nervous system

can become disrupted. The brain then becomes unable to properly send and receive messages. The type and severity of multiple sclerosis varies by the location and the extent of demyelination. It is estimated that multiple sclerosis affects approximately 2.5 million people worldwide, including 400,000 Americans. In recent years, the U.S. Food and Drug Administration (FDA) approved several biopharmaceutical and pharmaceutical products that have been shown to help slow the progression of multiple sclerosis, including Avonex®, Betaseron®, Copaxone® and Rebif®.

Specialty Infusion - Product Distribution

We distribute our products by specialized delivery services, including refrigerated delivery and expedited overnight mail or courier. Our products are shipped from our various wholesale or retail pharmacies and include the drugs, educational materials and any supplies necessary for the patient to administer the medication. In addition, the Specialty Infusion business unit provides intravenous infusion services to patients in their home by an experienced team of clinical professionals or in our ambulatory infusion suites located in some of our branch pharmacies.

Specialty Infusion - Product Suppliers

We purchase products directly from manufacturers and wholesale distributors. The majority of our hemophilia-related products is purchased from five suppliers with whom we have supply arrangements and our IVIG and other products from multiple suppliers.

Some of the products that we distribute, such as factor VIII blood-clotting products and IVIG products, have experienced shortages in the past due to the inability of suppliers to increase production to meet rising global demand. Although such shortages have ended, demand continues to grow. We are currently experiencing allocation restrictions of IVIG products. We currently have a contract to purchase a substantial amount of various pharmaceuticals that will expire in August 2006, one contract to purchase a substantial amount of factor that will expire in December 2006 and another contract to purchase medical supplies that will expire in March 2007. While we cannot be certain, we believe that under our arrangements with suppliers, we will have adequate supply of the products we offer, other than IVIG, to serve our existing patients and to add new patients in 2006.

Specialty Infusion - Strategy

The strategy of our Specialty Infusion business unit is to achieve same store sales growth by continuing to focus on our core therapies (hemophilia clotting factor, IVIG, anti-infective therapy and TPN) with which we have significant clinical experience, delivery capabilities and strong payor relationships. As of December 31, 2005, we operated 46 locally-based full service pharmacies where we endeavor to deliver positive clinical outcomes through locally-based clinical teams comprised of Company-employed pharmacists, nurses, dietitians and other experts. We continue to leverage and build upon our approximately 485 local, regional and national payor relationships. Utilizing our local presence, we plan to further expand our existing relationships and cultivate new opportunities with physician and hospital referral sources. We will expand into new disease states that require high-touch, local distribution, similar to our core therapies. We will use scale and clinical expertise to compete against both local and national competitors in the fragmented specialty pharmacy and home infusion markets. We also expect to grow by opening new locations that leverage our corporate infrastructure and state-level regulatory expertise and contacts. Additionally, we may selectively acquire complementary businesses that we believe will expand our service and product offerings and our customer base, deepen our penetration in existing markets and increase our operating leverage.

Specialty Infusion Marketing

We have assembled an industry-experienced sales force to execute our growth strategy. As of December 31, 2005, we had more than 85 Specialty Infusion sales and service representatives, 31 of whom are exclusively dedicated to servicing the hemophilia community. Our dedicated hemophilia sales and service representatives are responsible for distributing patient education materials, providing product inventory support, ensuring patient compliance according to their diagnoses and increasing the patient base they serve. The majority of our Specialty Infusion sales force is focused on selling our complete portfolio of core therapies directly to physicians, case managers and other patient influencers. They are responsible for enhancing existing relationships while developing new referral sources. Through our dedicated

contracting department, we continue to expand upon existing managed care relationships while adding new contracts.

Specialty Infusion - Payors

As of December 31, 2005, the Specialty Infusion business unit had approximately 485 payor contracts. We typically contract with large health maintenance organizations, major health insurers, government agencies and physician practices. The following provides approximate percentages of our Specialty Infusion business unit s patient revenues for the years ended December 31:

	2005	2004	2003
Private payors	65.2%	58.5%	40.6%
Medicaid	24.5%	32.4%	50.6%
Medicare	10.3%	9.1%	8.8%

Specialty Infusion - Reimbursement

The profitability of our Specialty Infusion operations depends, in large part, on the reimbursement we receive from third-party payors, including managed care organizations and Medicare and Medicaid programs. In recent years, competition for patients, efforts by traditional third-party payors to contain or reduce health care costs and the increasing influence of managed care payors, such as health maintenance organizations, have resulted in reduced rates of reimbursement for health care providers and suppliers. Changes in reimbursement policies of private and governmental third-party payors, including policies relating to Medicare, Medicaid and other federally funded programs, could reduce the amounts reimbursed to us for our products and services.

Our Specialty Infusion business unit offers a local reimbursement model for all of our products, supporting both the patient and payor. Prior to shipping the product or administering the product in the patient s home, our local reimbursement staff obtains authorization from the patient s insurer, easing the process for the patients and avoiding billing disputes with payors which might otherwise occur.

Many government payors, including Medicare (in 2004) and many state Medicaid programs, as well as a number of private payors, pay us directly or indirectly based upon a drug s AWP. Most of our Specialty Infusion business unit s revenues result from reimbursement methodologies based on the AWP of our products. The AWP for most drugs is compiled and published by third-party price reporting services, such as First DataBank, Inc., from information provided by manufacturers and/or wholesalers. Various federal and state government agencies have been investigating whether the published AWP of many drugs, including some that we distribute and sell, is an appropriate or accurate measure of the market price of the drugs. There are also several lawsuits pending against various drug manufacturers in connection with the appropriateness of the manufacturers AWP for a particular drug(s). These government investigations and lawsuits involve allegations that manufacturers reported artificially inflated AWPs of various drugs to third-party price reporting services, which, in turn, reported these prices to its subscribers, including many state Medicaid agencies who then included these AWPs in the state s reimbursement policies.

In December 2003, the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) was signed into federal law, providing for a Medicare prescription drug benefit and other changes to the Medicare program, including changes to payment methodologies for products we distribute that are covered by Medicare. Prior to MMA, Medicare reimbursement for many of the products we distribute was based on 95% of the products AWP. Under MMA, Medicare reimbursement for many of the products we distribute, including most physician-administered drugs and biologicals, was lowered to 80-85% of AWP effective January 1, 2004. This 2004 change did not affect Medicare reimbursement for blood-clotting factor products, which continued to be reimbursed at 95% of AWP during 2004.

Effective January 1, 2005, the Medicare reimbursement methodology for blood-clotting factor products changed from an AWP-based system to one based upon ASP which has lowered Medicare reimbursement. In addition to the payment we receive from the Medicare program for blood-clotting factor, beginning in January 2005, we receive a separate payment of $0.14 for each unit of factor furnished to Medicare beneficiaries. It is possible that states and/or commercial payors may adopt the new Medicare reimbursement methodology. In addition, MMA changes the relationship between the Medicare and Medicaid programs such that we may receive less reimbursement in the future for individuals who receive benefits under both of these programs.

In addition to these federal initiatives, many states are also making modifications to the manner with which they reimburse providers of pharmacy services. For example, in California, where approximately 5% and 12% of our total revenues for the years ended December 31, 2005 and 2004, respectively, were derived from blood-clotting products reimbursed by California state funded health programs, the state legislature in 2003 passed legislation that modified the reimbursement methodology for blood-clotting factor products under various California state funded health programs. Under the new reimbursement methodology, blood-clotting factor products are reimbursed based upon ASP, as provided by the manufacturers, plus 20%.

Effective June 1, 2004, Medi-Cal implemented the ASP reimbursement methodology for blood-clotting factor products which amounted to an approximate 30-40% cut from rates previously in effect. The implementation of the reduction in the reimbursement from Medi-Cal, and changes in regulations governing such reimbursement, has adversely impacted our revenues and profitability from the sale of products by us or by retail pharmacies to which we

provide products or services for hemophilia patients who are Medi-Cal beneficiaries or beneficiaries of other state funded programs for hemophilia patients.

In December, 2004, we and certain named individual plaintiffs entered into a Settlement Agreement which resolved both a lawsuit previously filed on behalf of two individual Medi-Cal recipients with hemophilia in the United States District Court for the Eastern District of California against the State of California relating to the implementation of the new ASP reimbursement methodology, and a lawsuit previously filed by us in the Superior Court for the County of Sacramento relating to, among other things, the State of California s failure to comply with certain applicable federal procedural requirements relating to the reimbursement rates. In return for dismissal of both lawsuits, DHS agreed to process, on a priority basis, all pending and future Medi-Cal, California Children s Services and Genetically Handicapped Persons Program claims submitted by us. In addition, DHS agreed to expedite its efforts to implement electronic billing and payment for blood-clotting factor claims.

In addition, the California legislature approved a proposal by the Governor of California to expand the Medi-Cal managed care program and to phase in mandatory enrollment for parents and children who are Medi-Cal beneficiaries. The Governor s proposal for mandatory enrollment of seniors and disabled individuals was rejected by the legislature, except for those individuals who may reside in an expansion county where a County Organized Health System (COHS) model is proposed. Under the COHS model, all eligible Medi-Cal beneficiaries are mandatorily enrolled into the managed care plan, including seniors and persons with disabilities. We understand there may be significant concern by various constituencies over mandatory enrollment of medically fragile populations, and the outcome of these proposals is uncertain at this time.

Specialty Infusion - Competition

We face a high degree of competition from companies in the specialty pharmacy and traditional home infusion industry. Our competitors include traditional home infusion providers, other specialty pharmacy companies, prescription benefit managers, retail chain pharmacies, mail order pharmacies, physician office infusion suites and hospital based pharmacies. We compete in areas such as quality of service, pricing, reliability and availability of pharmacists and patient service representatives. To remain competitive, our Specialty Infusion business unit must maintain strong relationships with physicians, hospitals, payors, patients and manufacturers.

WOUND CARE MANAGEMENT BUSINESS UNIT

Our Wound Care Management business unit is a leading provider of wound care management services that manages, on behalf of hospital clients, a nationwide network of Wound Care Center® programs that offer a comprehensive range of services for treatment of chronic wounds.

Financial information with respect to the Wound Care Management business unit, including information concerning revenues, operating profit from continuing operations and total assets may be found under Management s Discussion and Analysis of Financial Condition and Results of Operations and in Note 17 of Notes to Consolidated Financial Statements included elsewhere in this Annual Report on Form 10-K.

Wound Care Management - Market

Market overview. Chronic wounds are common in patients with diabetes and venous stasis disease, as well as patients who are immobilized and afflicted with pressure sores. A chronic wound generally is a wound which shows no signs of significant healing in four weeks or has not healed in eight weeks. The healing of a wound is dependent upon adequate blood flow to stimulate new cell growth and combat infection. When adequate blood flow does not occur, the healing process is retarded, often resulting in a chronic wound that can last for months or years. Without effective treatment, a chronic wound may lead to more severe medical conditions, such as infection, gangrene and amputation, which are costly to payors and impede the quality of life for the patient.

Traditional approach to chronic wound care. Traditional chronic wound care treatment, which is typically administered by a primary care physician, relies principally on cleansing and dressing the wound, controlling infection with antibiotics and protecting the wound. For example, topical or oral antibiotics are administered to decrease the bacterial count in the wound, protective dressings are used to decrease tissue trauma and augment repair and various

topical agents are applied that chemically cleanse the wound and remove wound exudate. These passive treatments do not directly stimulate the underlying wound healing process. In many cases, the patient may have to see a number of health care professionals before effective treatment is received. In addition, under this traditional care model, patients must manage their own care, which often leads to non-compliance and treatment failure which may lead to infection, gangrene and amputation. Although wound care programs have begun to evolve to more specialized and aggressive treatment regimens, we believe that a significant medical need and market opportunity exists for products and services that improve and accelerate the wound healing process.

Wound Care Management - The Curative Approach to Chronic Wound Care

Our Wound Care Management Program[SM] is a comprehensive array of diagnostic and therapeutic treatment regimens with all the components of care necessary to treat chronic wounds. The Wound Care Management Program[SM] is administered primarily through a nationwide network of Wound Care Center® programs. We believe the Wound Care Management Program[SM] provides a better approach to chronic wound management than the traditional approach, which we believe lacks a comprehensive solution, effective technology, positive outcomes and cost efficiency. Each Wound Care Management Program[SM] offers its patients an inter-disciplinary team of health care professionals, typically including general and specialty surgeons and a medical director, nurse, case manager, nutritionist and endocrinologist.

In most cases, patients arriving at a Wound Care Center® program have been treated with traditional wound healing techniques but continue to suffer from chronic wounds. In some cases, patients come to a Wound Care Center® program after they have received an opinion from their primary physician that limb amputation may be required. After being treated under our Wound Care Management Program[SM], for the quarter ended December 31, 2004, 101 out of 114 patients who were recommended for amputation, or approximately 88% did not require a limb amputation. Wound Care Management believes that this demonstrates the impact that the Wound Care Management business unit s Wound Management Program[SM] has on reducing health care costs and improving the quality of life. Upon the commencement of treatment under our Wound Management Program[SM], medical personnel conduct a systematic diagnostic assessment of the patient. Specialized treatment plans are then established for the patient, based on the underlying cause of the wound and the unique status of the patient. After the assessment phase, the course of treatment in the Wound Management Program[SM] may include revascularization, infection control, wound debridement, skin grafting, nutrition, protection devices, patient education, referrals and effective management of care through patient/provider communications.

To measure the effectiveness of our Wound Management Program[SM], we have developed a functional assessment scoring system to measure the healing of a wound. Under this system, a chronic wound is assessed when (i) it is less than 100% epithelialized (i.e., the wound is covered by a membranous cellular tissue that covers and protects a wound as it heals) and requires a dressing, (ii) it is completely covered by epithelium (i.e., a membranous cellular tissue that covers and protects a wound as it heals) but still requires intervention and dressing, (iii) maturing skin is present, but the wound requires a protective dressing and (iv) mature skin requires preventive care only. We have a proprietary database of patient outcomes that has been collected since 1988 containing over 534,000 patient records as of December 31, 2005 which indicate an overall healing rate of approximately 89% for patients completing therapy for the quarter ended December 31, 2005.

Wound Care Management - Strategy

The objective of our Wound Care Management business unit is to enhance its position as a leading disease management company in the chronic wound care market. Its growth strategy is to continue to improve and refine the Wound Management Program℠ while broadening its delivery models to cover the entire continuum of care for wound management. Key elements of this strategy include:

Continue to develop Wound Care Management business unit s nationwide network of outpatient Wound Care Center® programs. We intend to continue pursuing additional outpatient Wound Care Center® programs on or near the campuses of acute care hospitals. Since December 2003, the total number of net programs contracted and operating increased from 94 to 109 as of the end of 2005. Contract terminations have been effected for such reasons as reduced reimbursement, financial restructuring, hospital bankruptcies or closings. Additionally, we believe that hospitals choose to terminate or not renew contracts based upon decisions to terminate our programs or to operate them internally. As of December 31, 2005, Wound Care Management managed 103 operating outpatient Wound Care

Center® programs and believes there is opportunity for growth. We believe hospitals are continually seeking low-cost, high-quality solutions to wound management, such as those provided by Wound Care Management. In addition, we believe the Wound Management Program℠ enables its hospital clients to differentiate themselves from their competitors through better wound care treatment outcomes, reduced costs due to decreased inpatient lengths of stay and increased revenue through the introduction of new patients. As a result, we believe there is a significant opportunity for Wound Care Management to continue to expand its Wound Care Center® programs through affiliation with acute care hospitals.

In 2002, we signed a multi-year contract with VHA, Inc. (VHA), a cooperative representing more than 2,200 leading community-owned health care organizations and their affiliated physicians. Under this agreement, which was renewed in November of 2005, we offer wound management services to VHA members which comprise 25% of the community-owned hospitals in the United States, including many of the nation s largest and most respected institutions.

Develop new service models to enhance market penetration. We are actively developing new service models in new health care delivery settings, such as inpatient programs for acute care hospitals and long-term care facilities (e.g., nursing homes and long-term acute care hospitals). These new service models are being operated as a service to existing hospital customers and serve to expand the continuum of wound care services. Pressure sores, the most common form of a chronic wound, usually occur among nursing home, acute care and home care patients due to the sedentary lifestyle associated with those care settings. As we further develop our inpatient service models, we believe we will become more capable of penetrating the large pressure sore market, as acquired wounds are receiving increased scrutiny in post-acute and acute care quality requirements.

Provide a comprehensive managed care product. We believe that wound care represents a significant cost to managed care organizations and that Wound Care Management has the ability to provide a variety of services to managed care payors. These services may include, among others, case management, accreditation services and other tools necessary to effectively manage wound care patients. With its Wound Management Program℠ and increasing presence in multiple health care delivery settings, Wound Care Management can offer managed care payors a relationship which we believe will provide better patient healing outcomes, patient satisfaction and more cost-effective services for subscribers.

Enhance our Wound Management Program℠. Our Wound Care Management business unit currently offers a unique Wound Management Program℠ which includes assessment, vascular studies, revascularization, infection control, wound debridement, growth factor therapy, skin grafting, nutrition, protection devices, patient education, referrals and effective management of care through patient/provider communications. Wound Care Management is continually exploring and seeking advances in wound care management services and products which could enhance its current Wound Management Program℠. We are actively pursuing such advances through the continuous development of our current services and co-marketing arrangements with other providers of wound care products and services. Wound Care Management s current service offerings include furnishing hyperbaric oxygen services to interested hospital partners, forming alliances with companies marketing new wound care technologies and developing clinical research capabilities for the Wound Care Center® network.

Wound Care Management - Wound Care Operations

Wound Care Management s wound care operations offer health care providers the opportunity to create specialty wound care departments designed to meet the needs of chronic wound patients. The initial focus of Wound Care Management s wound care operations has been hospital outpatient Wound Care Center® programs. Wound Care Management is currently expanding its programmatic approach to wound care to inpatient settings, such as acute care hospitals and long-term care facilities. In these settings, Wound Care Management offers an inter-disciplinary approach to the treatment of chronic wounds in the inpatient settings to complement existing hospital Wound Care Center® programs.

Hospital outpatient Wound Care Center® programs. Outpatient Wound Care Center® programs, located on or near the campuses of acute care hospitals, represent Wound Care Management s core business. A typical hospital outpatient Wound Care Center® consists of approximately 2,500 square feet of space, comprised of four to eight exam rooms, a nursing station and physician and administrative offices. These Wound Care Center® programs are designed to deliver

all necessary outpatient services for the treatment of chronic wounds, with the hospital providing any inpatient care such as revascularization or surgical debridement.

Wound Care Management currently offers its hospital clients two outpatient Wound Care Center® models: a management model and an under arrangement model, with a primary focus on developing management models. The differences between these two models relate primarily to the employment of the clinical staff at the Wound Care Center® program. In the management model, generally our only employee at the Wound Care Center® program is the center s Program Director, and Wound Care Management generally receives a fixed monthly management fee or a combination of a fixed monthly management fee and a variable case management fee. In the under arrangement model, we employ most or all of the clinical and administrative staff (other than physicians) at the Wound Care Center® program, and structure our fees similarly to those of the management model with the exception of inclusion of fees to cover additional employee costs. In all other material respects, the two models are identical. In both models, physicians remain independent contractors, and Wound Care Management recruits and trains the physicians and staff associated with the Wound Care Center® program. The physicians providing services at a Wound Care Center® program are recruited by Wound Care Management, primarily from among the doctors who work at the hospital and practice in related areas. In addition, in both models, Wound Care Management s field support departments provide the staff at each Wound Care Center® program with clinical oversight, quality assurance, reimbursement consulting, community education and marketing, a proprietary database, training and general administrative support services. The terms of Wound Care Management s contract with each hospital are negotiated individually. Generally, in addition to the management fees described above, the contracts provide for development fees charged to the hospital. In both models, the hospital and the physician bill the patient for the services provided and are responsible for seeking reimbursement from insurers or other third-party payors.

The first Wound Care Center® program opened in 1988, and, as of December 31, 2005, there were 109 hospital outpatient Wound Care Center® programs in operation or under contract in approximately 30 states. In addition, in 2005, Wound Care Management entered into contracts with 18 hospitals to open additional Wound Care Center® programs. Wound Care Management s hospital client base ranges from medium-sized community-based hospitals to large hospitals affiliated with national chains and not-for-profit hospitals in local markets. Wound Care Management selects hospital clients based on a number of criteria. A suitable hospital client typically can accommodate at least 100 inpatient beds, has a primary and secondary market population greater than 100,000 people, offers services which complement the Wound Management Program℠, including physician specialists in the areas of general, plastic and vascular surgery, endocrinology and diabetes, is financially stable and has a solid reputation in the community it serves. Of Wound Care Management s 109 hospital outpatient Wound Care Center® programs, 105 are management model centers and 4 are under arrangement model centers.

In expanding its product offering, Wound Care Management furnishes hyperbaric oxygen therapy (HBO) services to interested hospital partners operating outpatient Wound Care Center® programs. These services generally include furnishing HBO chambers and managing the program. As of December 31, 2005, there were 28 HBO programs in operation or under contract complementing existing hospital outpatient Wound Care Center® programs of which 22 were operating and 6 were under contract.

Inpatient wound care programs. Wound Care Management is addressing the needs of the inpatient wound care market through the development of new inpatient programs. These patients often have pressure sores resulting from inactivity. While not typically as severe as diabetic or venous stasis ulcers, pressure sores represent the largest segment of the chronic wound market. Wound Care Management has developed an inpatient program for its affiliated

acute care hospitals that is directed at assisting those hospitals in identifying and managing inpatients in the acute care hospital that are at risk of acquired wounds or who already suffer from chronic wounds. The program is primarily directed at reducing the length of stay of those patients in the acute care setting and related wound care costs. Wound Care Management has also developed a Wound Outreach Program, whereby a nurse practitioner or physician assistant from an affiliated outpatient Wound Care Center® program provides wound-related services to long-term care facilities in surrounding areas. As of December 31, 2005, Wound Care Management had contracts to manage 32 such inpatient programs at existing acute-care hospital customers of which 23 were operating. Further, as of December 31, 2005, Wound Care Management had contracts to manage 25 programs that provide outreach wound care services to local long-term care facilities. There can be no assurance that these programs will be successful in the future.

Contracts terms and renewals. Substantially all of the revenues of the Wound Care Management business unit are derived from management contracts with acute care hospitals. The contracts generally have initial terms of three to five years and many have automatic renewal terms unless specifically terminated. The contracts often provide for early termination either by the client hospital, if specified performance criteria are not satisfied, or by Curative under various other circumstances. Historically, some contracts have expired without renewal, and others have been terminated by Wound Care Management or the client hospital for various reasons prior to their scheduled expiration. During 2005, two hospital contracts expired without renewal, and an additional four hospital contracts were terminated by the client hospital prior to their scheduled expiration. Generally, Wound Care Management elects to negotiate a mutual termination of a management contract if a client hospital desires to terminate the contract prior to its stated term. Wound Care Management believes that there were a number of reasons why hospitals chose to terminate their contract, including hospital financial difficulties and the Medicare reimbursement changes which reduced hospital revenues. The continued success of the Wound Care Management business unit is subject to its ability to renew or extend existing management contracts and obtain new management contracts. We believe that hospitals choose to terminate or not to renew contracts based on decisions to terminate their wound care programs or to convert their programs from independently-managed programs to programs operated internally. There can be no assurance that any hospital will continue to do business with Wound Care Management following the expiration of its management contract or earlier, if such management contract is terminable prior to expiration. In addition, any changes in the Medicare program or third-party reimbursement levels, which generally have the effect of limiting or reducing reimbursement levels for health services provided by programs managed by Wound Care Management, could result in the early termination of existing management contracts and would adversely affect the ability of Wound Care Management to renew or extend existing management contracts and to obtain new management contracts. The termination or non-renewal of a material number of management contracts could harm our business.

Managed care operations. Wound Care Management s managed care strategy is currently focused on marketing Wound Care Center® program services to local managed care organizations in concert with its hospital clients efforts to promote all hospital-based services to such managed care organizations. Wound Care Management seeks to establish relationships with managed care organizations and other disease management companies to provide wound care services. Wound Care Management s contractual arrangements with managed care organizations and other disease management companies, which will vary based upon the needs of the particular customer, are expected to provide for Wound Care Management to receive compensation on a fee-for-service, fixed-case rate or at-risk capitation basis. While Wound Care Management anticipates that most of its managed care contracts will be fee-for-service or case-rate contracts, it expects that at-risk capitation could become a contracting method.

Wound Care Management has developed tools to help managed care organizations and other disease management companies assess their current wound care experiences (both clinical results and costs) against our Wound Management Program℠ in order to demonstrate that a wound care carve-out product can provide added value. To date, Wound Care Management has been unsuccessful in establishing managed care or disease management relationships.

Wound Care Management s managed care operations have been limited. Although Wound Care Management or its hospital clients have been reimbursed for wound treatment by a number of managed care organizations on a case-by-case basis, Wound Care Management currently has no contracts that require or offer incentives to subscribers to use Wound Care Management s wound care services. There can be no assurance that Wound Care Management will be able to successfully expand its managed care operations.

Wound Care Management - Community Education and Marketing

Wound Care Management s community education and marketing strategy consists of a two-fold approach involving the development of new wound care programs as well as the growth in operating Wound Care Center® programs. The professional community education component is locally managed and conducted by the Wound Care Center® Program Directors under the supervision of the Regional Managers with support from Community Education Managers. The primary community education efforts are directed at physicians and other health care professionals to expand community awareness of the Wound Care Center® program services.

In addition, community education marketing plans are developed each year at each Wound Care Center® program. The development and execution of the plan is the responsibility of the Program Director at the Wound Care Center® along with the Corporate Marketing Department. The plan details the anticipated marketing for the year and may

include radio and print advertising as well as professional symposiums and other community education. Wound Care Management markets the Wound Care Center® program concept to hospitals as a therapeutic Center of Excellence. Wound Care Management believes that having a Wound Care Center® program can differentiate a hospital from its competitors and can increase the hospital s revenues through the introduction of new patients, which leads to an increase in appropriate ambulatory surgeries, X-rays, laboratory tests and inpatient surgeries such as debridements, vascular surgeries and plastic surgeries.

Wound Care Management s efforts to develop new wound management programs is the responsibility of the Directors of Business Development, whose primary role is the development of new wound care programs with acute care hospitals. As of December 31, 2005, Wound Care Management had four Directors of Business Development.

Wound Care Management Third-Party Reimbursement

Wound Care Management, through its wound care operations, provides contractual management services for fees to acute care hospitals and other health care providers. These providers, in turn, seek reimbursement from third-party payors, such as Medicare, Medicaid, health maintenance organizations and private insurers, for clinical services rendered to patients insured by these payors. The availability of reimbursement from such payors has been a significant factor in Wound Care Management s ability to increase its revenue streams and will be important for future growth.

Each third-party payor formulates its own coverage and reimbursements policies. Although we have not, and we believe that our clients have not, in general experienced difficulty in securing third-party reimbursement for Wound Care Center® program services, some hospitals have experienced denials, delays and difficulties in obtaining such reimbursement. To our knowledge, no widespread denials have been received by hospitals regarding reimbursement for Wound Care Center® program clinical services. We discuss coverage and reimbursement issues with our hospital clients and third-party payors on a regular basis. Such discussions will continue as we seek to assure sufficient payments from third-party payors to our hospital customers for services managed by us so that our hospital customers and potential customers find it financially feasible to renew contracts or enter into contracts with Wound Care Management. Although no individual coverage and reimbursement decision is material to us, a widespread denial of reimbursement coverage for clinical services provided in the Wound Care Center® programs could have a material adverse effect on our business, financial position and results of operations.

As a result of the Balanced Budget Act of 1997, the Centers for Medicare & Medicaid Services (CMS) implemented the Outpatient Prospective Payment System for most hospital outpatient department services furnished to Medicare patients beginning August 2000, under which a predetermined rate is paid to each hospital for clinic services rendered, regardless of the hospital s cost. We believe the new payment system does not provide comparable reimbursement for services previously reimbursed on a reasonable cost basis, and we believe the payment rates for many services are insufficient for many of our hospital customers, resulting in revenue and income shortfalls for the Wound Care Center® programs we manage on behalf of the hospitals. As a result, during 2004, we renegotiated and modified many of our management contracts related to our Wound Care Management business unit, which has resulted in reduced revenue and income to us from those modified contracts and, in numerous cases, contract termination. We expect that contract renegotiation and modification with many of our hospital customers will continue, and this could result in reduced revenues and income to us from those contracts and even contract terminations. These results could have a material effect on Wound Care

Management s business, financial condition and results of operations.

The Wound Care Center® programs managed by our Wound Care Management business unit on behalf of acute care hospitals are generally treated as provider based entities for Medicare reimbursement purposes. This designation is required for the hospital-based program to be covered under the Medicare outpatient reimbursement system. Although we believe that the programs we manage substantially meet the current criteria to be designated provider based entities, a widespread denial of such designation could harm our business.

Wound Care Management - Competition

Our principal competition in the chronic wound care market consists of specialty clinics that have been established by some hospitals or physicians. Additionally, there are a number of private companies which provide wound care services through an HBO program format. In the market for disease management products and services, we face competition from other disease management entities, general health care facilities and service providers, biopharmaceutical companies, pharmaceutical companies and other competitors. Many of these companies have substantially greater capital resources, marketing staffs and experience in commercializing products and services than we have. In addition, recently developed technologies, or technologies that may be developed in the future, are or may be the basis for products which compete with our chronic wound program. There can be no assurance that we will be able to enter into co-marketing arrangements with respect to these products or that we will be able to compete effectively against such companies in the future.

GOVERNMENT REGULATION

Our operations and the marketing of our services are subject to extensive regulation by numerous governmental authorities in the United States, both federal and state. We believe that we are currently in substantial compliance with applicable laws, regulations and rules. However, there can be no assurance that a governmental agency or a third party will not contend that certain aspects of our business are subject to or are not in compliance with such laws, regulations or rules or that the state or federal regulatory agencies or courts would interpret such laws, regulations and rules in our favor. The sanctions for failure to comply with such laws, regulations or rules could include denial of the right to conduct business, significant fines and criminal and civil penalties. Additionally, an increase in the complexity or substantive requirements of such laws, regulations or rules could have a material adverse effect on our business.

Any change in current regulatory requirements or related interpretations by, or positions of, state officials in states where we operate could adversely affect our operations within those states. In states where we are not currently located but where we may operate in the future, we intend to utilize the same approaches adopted elsewhere for achieving state compliance. However, state regulatory requirements could adversely affect our ability to establish operations in such other states.

Various state and federal laws and agencies regulate providers of health care services and suppliers of biopharmaceutical and pharmaceutical products, including the products and services that we distribute and sell. These laws include, but are not limited to, the following:

Licensure and Registration

We are required by various states to be licensed as an in-state pharmacy and, within most other states where we distribute prescription drugs, we are required to be licensed as an out-of-state pharmacy.

In addition, federal controlled substance laws mandate that we register our pharmacy and repackaging locations with the federal Drug Enforcement Administration as well as conform with recordkeeping, labeling and security regulations when dispensing controlled substances.

We believe that we are currently in substantial compliance with all state licensing and registration laws applicable to our business. However, if we are found to not be in compliance, we could be subject to fines and penalties which could have an adverse effect on our business.

Fraud and Abuse Laws

These laws, specifically the anti-kickback laws, include the fraud and abuse provisions and referral restrictions of the Medicare and Medicaid statutes, as well as other federally funded programs, which prohibit the solicitation, payment, receipt or offering of any direct or indirect remuneration for the referral of Medicare and Medicaid patients or for purchasing, arranging for or recommending the purchasing, leasing or ordering of Medicare or Medicaid covered services, items or equipment.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created violations for fraudulent activity applicable to both public and private health care benefit programs and prohibits inducements to Medicare or Medicaid eligible patients.

The Office of Inspector General (OIG) from time to time publishes its interpretations on various fraud and abuse issues and about fraudulent or abusive activities OIG deems suspect and potentially in violation of the federal laws, regulations and rules. If our actions are found to be inconsistent with OIG s interpretations, such actions could have a material adverse effect on our business.

Due to the complexity of such anti-kickback laws, HHS has established certain safe harbor regulations whereby various payment practices may be protected from criminal or civil penalties. However, an activity that is outside a safe harbor is not necessarily deemed illegal.

Violations of these fraud and abuse laws may result in fines and penalties as well as civil or criminal penalties for individuals or entities, including exclusion from participation in the Medicare or Medicaid programs. Several states have adopted similar laws that cover patients in both private and government programs. Because the anti-fraud and abuse laws have been broadly interpreted, they limit the manner in which we can operate our business and market our services to, and contract for services with, other health care providers.

The Stark Law

Federal and some state laws impose restrictions on the relationships between providers of health care services or products and other persons or entities, such as physicians and other clinicians, including with respect to employment or service contracts, investment relationships and referrals for certain designated health services. Outpatient prescription drugs are one of the designated services to which the Stark Law applies. On March 26, 2004, CMS issued the second phase of its final regulations addressing physician self-referrals, which became effective July 24, 2004. We believe we have structured our operations in an attempt to comply with these provisions. Periodically, there are efforts to expand the scope of these referral restrictions from its application to government health care programs to all payors and to additional health care services. Certain states are considering adopting similar restrictions or expanding the scope of existing restrictions. There can be no assurance that the federal government, or other states in which we operate, will not enact similar or more restrictive legislation or restrictions or interpret existing laws and regulations in a manner that could harm our business.

Professional Fee Splitting

The laws of many states prohibit physicians from sharing professional fees with non-physicians and prohibit non-physician entities, such as us, from practicing medicine and from employing physicians to practice medicine. The laws in most states regarding the corporate practice of medicine have been subjected to judicial and regulatory interpretation.

Pharmacy Operation Laws

Our pharmacies are subject to various state laws relating to pharmacy operation, including requirements regarding licensure and handling, securing, storing, labeling, dispensing, recordkeeping and reporting for pharmaceutical products, as well as patient confidentiality requirements and prohibitions on fee-splitting by pharmacies. Additionally, many state boards of pharmacy require pharmacies to provide counseling to customers. Our pharmacy business marketing activities may also be regulated by the FDA, including with respect to any promotion of off-label uses of products (for indications which have not been approved by the FDA). We believe we are in substantial compliance with these requirements. However, if we are found not to be in compliance, we could be subject to fines and penalties which could have an adverse effect on our business.

Professional Licenses

State laws prohibit the practice of medicine, pharmacy and nursing without a license. To the extent that we assist patients and providers with prescribed treatment programs, a state could consider our activities to constitute the practice of medicine. In addition, in some states, coordination of nursing services for patients could necessitate licensure as a home health agency or other licensed entity and/or could necessitate the need to use licensed nurses to provide certain

patient directed services. If we are found to have violated state licensure laws, we could face civil and criminal penalties and be required to reduce, restructure or even cease our business in that state.

False Claims Act

Federal and some state laws impose requirements in connection with the submission of claims for payment for health care services and products, including prohibiting the knowing submission of false or fraudulent claims and submission of false records or statements. Such requirements would apply to the operations of our pharmacies and to the hospital customers to which we provide wound care management services. Not only are government agencies active in investigating and enforcing actions with respect to applicable health laws, but also health care providers are often subject to actions brought by individuals on behalf of the government. As such suits are generally filed under seal with a court to allow the government adequate time to investigate and determine whether it will intervene in the action, implicated health care providers are often unaware of the suit until the government has made its determination and the seal is lifted.

The federal False Claims Act (the False Claims Act) generally provides for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial penalties for small billing errors that are replicated in a large number of claims, as each individual claim could be deemed to be a separate violation of the False Claims Act. Criminal provisions that are similar to the False Claims Act provide that if a corporation is convicted of presenting a claim or making a statement that it knows to be false, fictitious or fraudulent to any federal agency, it may be fined. Some states also have enacted statutes similar to the False Claims Act which may include criminal penalties, substantial fines and treble damages.

HIPAA - Administrative Simplification and other State and Federal Privacy Laws

The Administrative Simplification Provisions of HIPAA required HHS to adopt standards to protect the security and privacy of health-related information. In February 2002, HHS issued final rules concerning the security standards. These rules do not require the use of specific technologies (e.g., no specific hardware or software is required), but instead require health plans, health care clearinghouses and health care providers to comply with certain minimum security procedures in order to protect data integrity, confidentiality and availability. These security regulations, with which compliance was required as of April 2005, impose on covered entities certain administrative, technical, and physical safeguard requirements with respect to individually identifiable health information maintained or transmitted electronically.

The privacy regulations, with which compliance was required as of April 2003, impose on covered entities (including hospitals, pharmacies and other health care providers) significant new restrictions on the use and disclosure of individually identifiable health information. Improper use or disclosure of identifiable health information covered by HIPAA privacy regulations can result in the following fines and/or imprisonment: (i) civil money penalties for HIPAA privacy violations are $100 per incident, up to $25,000, per person, per year, per standard violated; (ii) a person who knowingly and in violation of HIPAA privacy regulations obtains individually identifiable health information or discloses individually identifiable health information to another person may be fined up to $50,000 and imprisoned up to one year, or both; (iii) if the offense is committed under false pretenses, the fine may be up to $100,000 and imprisonment for up to five years; and (iv) if the offense is done with the intent to sell, transfer or use individually identifiable health information for commercial advantage, personal gain or malicious harm, the fine may be up to $250,000 and imprisonment for up to ten years.

HIPAA also required HHS to adopt national standards establishing electronic transaction standards that all health care providers must use when submitting or receiving certain health care transactions electronically. Although these standards were to become effective October 2002, Congress extended the compliance deadline until October 2003 for organizations, such as ours, that submitted a request for an extension. We have taken the appropriate actions to ensure that patient data kept on our computer networks are in compliance with these regulations. We believe that we are substantially in compliance with the HIPAA electronic standards and are capable of delivering HIPAA standard transactions electronically. In addition, if we choose to distribute drugs through new distribution channels, such as the Internet, we will have to comply with government regulations that apply to those distribution channels, which could harm our business.

In addition to HIPAA, a number of states have adopted privacy laws and/or regulations applicable to the use and disclosure of patient health information that are more stringent than comparable provisions under HIPAA. If we were found to have violated one of these state laws, we could be subject to fines, penalties and other actions which could have an adverse effect on our business.

Ongoing Investigations

Federal and state investigations and enforcement actions continue to focus on the health care industry, scrutinizing a wide range of items such as joint venture arrangements, referral and billing practices, product discount arrangements, home health care services, dissemination of confidential patient information, promotion of off-label drug indications use, clinical drug research trials and gifts for patients or referral sources. We believe our current and planned activities are substantially in compliance with applicable legal requirements. There can be no assurance, however, that a governmental agency or a third party will not contend that certain aspects of our business are subject to, or are not in compliance with, such laws, regulations or rules, or that state or federal regulatory agencies or courts would interpret such laws, regulations and rules in our favor, or that future interpretations of such laws will not require structural or organizational modifications of our existing business or have a negative impact on our business. Applicable laws and regulations are very broad and complex, and, in many cases, the courts interpret them differently, making compliance difficult. Although we try to comply with such laws, regulations and rules, a violation could result in denial of the right to conduct business, significant fines and criminal penalties. Additionally, an increase in the complexity or substantive requirements of such laws, regulations or rules, or reform of the structure of health care delivery systems and payment methods, could have a material adverse effect on our business.

INTELLECTUAL PROPERTY

Our success depends, in part, on our ability to maintain trade secret protection and operate without infringing on or violating the proprietary rights of third parties. In addition, we also rely, in part, on trade secrets, proprietary know-how and technological advances which we seek to protect by measures, such as confidentiality agreements with our employees, consultants and other parties with whom we do business. There can be no assurance that these agreements will not be breached, that we will have adequate remedies for any breach or that our trade secrets and proprietary know-how will not otherwise become known, be independently discovered by others or found to be unprotected.

Wound Care Center®, Wound Care Management Program℠, the name Critical Care Systems® and its logo and our logo with our name, Curative Health Services®, are our trademarks. This report also includes trade names and marks of other companies.

EMPLOYEES

As of December 31, 2005, we employed 1,292 full-time, part-time and per diem hourly employees, including skilled health care professionals such as nurses, pharmacists, hospital administrators, community based representatives, reimbursement specialists and patient service representatives in 46 states and the District of Columbia. The Specialty Infusion business unit employed 1,102 of such employees and 190 employees were employed by the Wound Care Management business unit. We believe that our relations with our employees are good.

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ITEM 1A. RISK FACTORS

The statements contained in this Annual on Form 10-K include forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 (the PSLRA). When used in this Annual Report on Form 10-K and in future filings by us with the Securities and Exchange Commission (the SEC), in our news releases, presentations to securities analysts or investors, and in oral statements made by or with the approval of one of our executive officers, the words or phrases believes, anticipates, expects, plans, seeks, intends, will likely result, estimates, projects or similar expressions are intended to identify such forward-looking statements. These statements are only predictions. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance or achievements. Actual events or results may differ materially from the results discussed in the forward-looking statements.

The following text contains cautionary statements regarding our business that investors and others should consider. This discussion is intended to take advantage of the safe harbor provisions of the PSLRA. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings with the SEC or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications. You should not place undue reliance on forward-looking statements, which speak only as of the date they are made. In addition, any of the matters discussed below may have affected past, as well as current, forward-looking statements about future results so that our actual results in the future may differ materially from those expressed in prior communications.

CERTAIN BANKRUTPCY CONSIDERATIONS

Under the terms of our Plan, we expect our existing shareholders investment to be extinguished and intend to become a private company.

If our Plan is confirmed and implemented, existing common stock will be cancelled and current shareholders will receive no distribution or other consideration in exchange for their shares. Furthermore, effective February 21, 2006, Curative s existing common stock was delisted from the NASDAQ National Market System. Since that date, Curative s existing common stock has been quoted in the over-the-counter market.

In connection with the reorganization to be effected by the Plan, we intend to deregister our existing securities under the Securities Exchange Act of 1934, and become a private company upon our emergence from Chapter 11. After such time, Curative s obligation to file reports and other information under the Securities Exchange Act of 1934, such as Forms 10-K and 10-Q, will be terminated.

Operating in bankruptcy imposes significant risks on our operations. We cannot predict when we will confirm a plan of reorganization and successfully emerge from bankruptcy.

The timing of our emergence from bankruptcy and the terms of our emergence may affect our relationships with our creditors, customers, suppliers and employees and have a significant impact on our business, financial condition and results of operations. If our bankruptcy is protracted, our ability to continue operating in bankruptcy as a going concern and to emerge from bankruptcy will depend upon the following factors, among others:

our management s ability to balance time and effort dealing with the reorganization and business operations at the same time in a prolonged continuation of our Chapter 11 Cases;

our ability to obtain additional financing, either as a part of the debtor-in-possession financing or otherwise, during the pendency of our Chapter 11 Cases on commercially favorable terms;

our ability to comply with and operate under the terms of the debtor-in-possession financing we obtained upon filing for bankruptcy and any cash management orders entered by the bankruptcy court from time to time;

our ability to pay costs for professional fees and other expenses associated with the Chapter 11 Cases;

our ability to attract and retain management and other key employees; and

our ability to maintain good customer and supplier relationships in light of developments in our bankruptcy proceedings and the terms of our emergence.

We may not be able to obtain confirmation of the Plan.

Even if we received the requisite acceptances to confirm the Plan, a number of factors could result in the Bankruptcy Court not confirming the Plan. Even if the Bankruptcy Court determined that the balloting procedures and results were appropriate, the Bankruptcy Court could still decline to confirm the Plan if it found that any of the statutory requirements for confirmation had not been met, including that the terms of the Plan are fair and equitable to non-accepting classes. Section 1129 of the Bankruptcy Code sets forth the requirements for confirmation and requires, among other things, a finding by the Bankruptcy Court that:

the Plan does not unfairly discriminate and is fair and equitable with respect to any non-accepting classes;

confirmation of the Plan is not likely to be followed by a liquidation or a need for further financial reorganization; and

the value of distributions to non-accepting holders of claims within a particular class under the Plan will not be less than the value of distributions such holders would receive if the debtors were liquidated under Chapter 7 of the Bankruptcy Code.

The Bankruptcy Court may determine that the Plan does not satisfy one or more of these requirements, in which case it would not be confirmable by the Bankruptcy Court.

If the Plan is not confirmed by the Bankruptcy Court, it is unclear whether we will be able to reorganize our businesses and what, if any, distributions holders of claims against Curative ultimately would receive with respect to their claims. If an alternative reorganization could not be agreed upon, it is possible that we would have to liquidate our assets, in which case it is likely that holders of claims would receive substantially less favorable treatment than they would receive under the Plan.

For further information regarding the status of our Chapter 11 Cases, please see Note 1 of Notes to Consolidated Financial Statements included elsewhere in this Annual Report on Form 10-K.

BUSINESS AND INDUSTRY RISKS

We are involved in litigation which may harm the value of our business.

In addition to the Chapter 11 Cases discussed under the caption, Planned Reorganization and Chapter 11 Bankruptcy Proceedings, two of our subsidiaries, Apex and eBioCare, might be subject to potential indemnification liabilities to three independent retail pharmacies that previously did business with us. The indemnification claims are in connection with the DHS Audit related to the pharmacies medical billing for clotting factor supplied to the pharmacies by Apex and eBioCare, and the pharmacies medical billing for the anti-inhibitor product FEIBA supplied to the pharmacies by Apex and eBioCare. While liability with respect to these claims is not certain at this time, Apex and eBioCare believe that some amount of monetary loss is reasonably possible if the pharmacies assert and prevail on indemnification claims. Apex and eBioCare estimate that the range of loss may be anywhere from $0 to $39.3 million.

In the normal course of our business, we are involved in lawsuits, claims, audits and investigations, including any arising out of services or products provided by or to our operations, personal injury claims, employment disputes and contractual claims, the outcome of which, in our opinion, should not have a material adverse effect on our financial position and results of operations. However, we may become subject to future lawsuits, claims, audits and investigations that could result in substantial costs and divert our attention and resources.

If we fail to comply with the terms of our settlement agreement with the government, we could be subject to additional litigation or other governmental actions which could be harmful to our business.

On December 28, 2001, we entered into a settlement with the U.S. Department of Justice (DOJ), the U.S. Attorney for the Southern District of New York, the U.S. Attorney for the Middle District of Florida and the U.S. Department of Health and Human Services, Office of the Inspector General, in connection with all federal investigations and legal proceedings related to whistleblower lawsuits previously pending against us in the U.S. District Court for the Southern District of New York and the U.S. District Court for the District of Columbia. These lawsuits included allegations that we improperly caused our hospital customers to seek reimbursement for a portion of our management fees that included costs related to advertising and marketing activities by our personnel and allegations that we violated the federal anti-kickback law and the federal False Claims Act. Under the terms of the settlement, the lawsuits were dismissed, the United States and the whistleblowers released us from the claims asserted in the lawsuits, and we agreed to pay to the United States a $9.0 million initial payment, with an additional $7.5 million to be paid over the next four years. As of December 31, 2005, a balance of approximately $0.4 million was outstanding on this obligation. Pursuant to the settlement, we have been required to fulfill certain additional obligations, including abiding by a five-year Corporate Integrity Agreement, avoiding violations of law and providing certain information to the DOJ from time to time. As of December 17, 2003, we were released from part of our obligations under the Corporate Integrity Agreement. The independent review organization that conducts the audit of our records pursuant to the Corporate Integrity Agreement is no longer required to conduct the general compliance review. If we fail or if we are accused of failing to comply with the terms of the settlement, we may be subject to additional litigation or other governmental actions, including our Wound Care Management business unit being barred from participating in the Medicare program and other federal health care programs. In addition, as part of the settlement, we consented to the entry of a judgment against us for $28.0 million, less any amounts previously paid under the settlement, that would be imposed only if we fail to comply with the terms of the settlement, which, if required to be paid, could have a material adverse effect on our financial position.

The industry in which we operate is subject to extensive government regulation, and non-compliance by us, our suppliers, our customers or our referral sources could harm the business.

The marketing, labeling, dispensing, storing, provision, selling, pricing and purchasing of drugs, health supplies and health services, including the biopharmaceutical products we provide, are extensively regulated by federal and state governments, and if we fail or are accused of failing to comply with laws and regulations, our business could be harmed. Our business could also be harmed if the suppliers, customers or referral sources we work with are accused of violating laws or regulations. The applicable regulatory framework is complex, and the laws are very broad in scope. Many of these laws remain open to interpretation and have not been addressed by substantive court decisions. The federal government or states in which we operate could, in the future, enact more restrictive legislation or interpret existing laws and regulations in a manner that could limit the manner in which we can operate our business and have a negative impact on our business.

A substantial percentage of our revenue is attributable to the Medicaid and Medicare programs and has been significantly adversely impacted by recent changes in Medi-Cal reimbursement policies and will continue to be subject to changes in reimbursement policies and other legislative or regulatory initiatives aimed at reducing costs associated with various government programs.

In the year ended December 31, 2005, approximately 24.5%of our Specialty Infusion business unit revenues were derived from products and/or services provided to patients covered under various state Medicaid programs, most of which were from California, and approximately 10.3% of our Specialty Infusion business unit s revenues were derived from products and/or services provided to patients covered under the Medicare program. Such programs are highly regulated and subject to frequent and substantial changes and cost-containment measures that may limit and reduce payments to providers. In the recent past, many states experienced budget deficits that may require future reductions in health care related expenditures. State cost containment activity continued to focus heavily on reducing provider payments and controlling prescription drug spending.

In December 2003, MMA was signed into federal law, providing for a Medicare prescription drug benefit and other changes to the Medicare program, including changes to payment methodologies for products we distribute that are covered by Medicare. Prior to MMA, Medicare reimbursement for many of the products we distribute was based on 95% of the products AWP. Under MMA, Medicare reimbursement for many of the products we distribute, including most physician-administered drugs and biologicals, was lowered to 80-85% of AWP effective January 1,

2004. This 2004 change did not affect Medicare reimbursement for blood-clotting factor products, which continued to be reimbursed at 95% of AWP during 2004.

Effective January 1, 2005, the Medicare reimbursement methodology for blood-clotting factor products changed from an AWP-based system to one based upon ASP which has lowered Medicare reimbursement. In addition to the payment we receive from the Medicare program for blood-clotting factor, beginning in January 2005, we receive a separate payment of $0.14 for each unit of factor furnished to Medicare beneficiaries. It is possible that states and/or commercial payors may adopt the new Medicare reimbursement methodology. The conversion to a system based upon ASP could have a material adverse effect on our business, financial condition and results of operations. In addition, MMA changes the relationship between the Medicare and Medicaid programs such that we may receive less reimbursement in the future for individuals who receive benefits under both of these programs.

In addition to these federal initiatives, many states are also making modifications to the manner with which they reimburse providers of pharmacy services. For example, in California, where approximately 5% of our total revenues for the year ended December 31, 2005 was derived from blood-clotting products reimbursed by California state funded health programs, the state legislature in 2003 passed legislation that modified the reimbursement methodology for blood-clotting factor products under various California state funded health programs. Under the new reimbursement methodology, blood-clotting factor products are reimbursed based upon ASP, as provided by the manufacturers, plus 20%.

Effective June 1, 2004, Medi-Cal implemented the ASP reimbursement methodology for blood-clotting factor products, which amounted to an approximate 30-40% cut from rates previously in effect. The implementation of the reduction in the reimbursement from Medi-Cal, and changes in regulations governing such reimbursement, has adversely impacted our revenues and profitability from the sale of products by us or by retail pharmacies to which we provide products or services for hemophilia patients who are Medi-Cal beneficiaries or beneficiaries of other state funded programs for hemophilia patients.

In December, 2004, we and certain named individual plaintiffs entered into a Settlement Agreement which resolved both a lawsuit previously filed on behalf of two individual Medi-Cal recipients with hemophilia in the United States District Court for the Eastern District of California against the State of California relating to the implementation of the new ASP reimbursement methodology, and a lawsuit previously filed by us in the Superior Court for the County of Sacramento relating to, among other things, the State of California s failure to comply with certain applicable federal procedural requirements relating to the reimbursement rates. In return for dismissal of both lawsuits, DHS agreed to process, on a priority basis, all pending and future Medi-Cal, California Children s Services and Genetically Handicapped Persons Program claims submitted by us. In addition, DHS agreed to expedite its efforts to implement electronic billing and payment for blood-clotting factor claims. There can be no assurance, however, that the Company s accounts receivable collections from the State of California will improve as the result of this settlement agreement. A failure of the Company to improve its accounts receivable collections from the State of California could have a material adverse effect on the Company s business, financial condition and operating results.

In addition, the California legislature approved a proposal by the Governor of California to expand the Medi-Cal managed care program into additional counties and to phase in mandatory enrollment for parents and children who are Medi-Cal beneficiaries. The Governor s proposal for mandatory enrollment of seniors and disabled individuals was rejected by the legislature, except for those individuals who may reside in an expansion county where a COHS model is proposed. Under the COHS model, all eligible Medi-Cal beneficiaries are mandatorily enrolled into the managed care plan, including seniors and persons with disabilities. We understand there may be significant concern by various constituencies over mandatory enrollment of medically fragile populations, and the outcome of these proposals is not certain at this time.

We are in the process of evaluating the impact various federal and state legislative and related initiatives may have on our business, financial position and results of operations.

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Our growth strategy includes the expansion of our branch pharmacy network by the opening of new branch pharmacy locations.

An important element of the growth strategy of our Specialty Infusion business unit is the expansion of our branch pharmacy network through the opening of new branch locations. This expansion will involve significant planning and execution processes, such as identifying new markets, leasing facility space, hiring qualified personnel, obtaining payor contracts and obtaining patient referrals. In addition, we will need to invest capital in facility build out, computers, offices and other furniture and equipment. It is expected that these branch pharmacies will incur losses during their startup periods. Any failure by us to effectively execute this expansion strategy, including the successful transition of expansion branches from loss positions to profitability, could have a material adverse effect on our business, financial condition, operating results and cash flows.

We have experienced rapid growth by acquisitions. If we are unable to manage our growth effectively or purchase or integrate new companies, our business could be harmed.

Our growth strategy will likely strain our resources, and if we cannot effectively manage our growth, our business could be harmed. In connection with our growth strategy, we will likely experience an increase in the number of our employees in our branch network, the size of our programs and the scope of our operations. Our ability to manage this growth and to be successful in the future will depend partly on our ability to retain skilled employees, enhance our management team and improve our management information and financial control systems.

As part of our growth strategy, we may evaluate acquisition opportunities. Acquisitions involve many risks, including the following:

Since the specialty pharmacy industry is undergoing consolidation, we may experience difficulty in identifying suitable candidates and negotiating and consummating acquisitions on attractive terms, if at all.

In the industry in which our Specialty Infusion business unit operates, there are customers who have a strong affiliation with their community-based representatives; accordingly, we may experience difficulty in retaining and assimilating the community-based representatives of companies it acquires.

Because of the relationships between community-based representatives and customers in certain of our product lines, the loss of a single community-based representative may entail the loss of a significant amount of revenue.

Our operational, financial and management systems may be incompatible with or inadequate to cost effectively integrate and manage the acquired business systems. As a result, billing practices could be interrupted, and cash collections on the newly acquired business could be delayed pending conversion of patient files onto our billing systems and receipt of provider numbers from government payors.

A growth strategy that involves significant acquisitions diverts management s attention from existing operations.

Acquisitions may involve significant transaction costs which we may not be able to recoup.

We may not be able to integrate newly acquired businesses appropriately.

In addition, we may become subject to litigation and other liabilities resulting from the conduct of an acquired business prior to its acquisition by us.

We operate in a rapidly changing, consolidating and competitive environment. If we are unable to adapt quickly to these changes, our business and results of operations could be seriously harmed.

The specialty infusion industry is experiencing rapid consolidation. We believe that technological and regulatory changes will continue to attract new entrants to the market. Industry consolidation among our competitors may increase their financial resources, enabling them to compete more effectively based on price and services offered. This could require us either to reduce our prices or increase our service levels, or risk losing market share. Moreover, industry consolidation may result in stronger competitors that are better able to compete.

If we are unable to effectively execute our growth strategy, our ability to compete in a rapidly changing and consolidating specialty pharmacy industry may be negatively impacted.

We may need additional capital to finance our growth and capital requirements, which could prevent us from fully pursuing our growth strategy.

In order to implement our present growth strategy, we may need substantial capital resources and may incur, from time to time, short- and long-term indebtedness, the terms of which will depend on market and other conditions. Due to uncertainties inherent in the capital markets (*e.g.,* availability of capital, fluctuation of interest rates, etc.), we cannot be certain that existing or additional financing will be available to us on acceptable terms, if at all. Even if we are able to obtain additional debt financing, we may incur additional interest expense, which may decrease our earnings, or we may become subject to contracts that restrict our operations. As a result, we could be unable to fully pursue our growth strategy. Further, additional financing may involve the issuance of equity securities that would dilute the interests of our existing shareholders and potentially decrease the market price of our common stock.

An impairment of the significant amount of goodwill on our financial statements could adversely affect our results of operations.

Our specialty infusion acquisitions resulted in the recording of a significant amount of goodwill on our financial statements. The goodwill was recorded because the fair value of the net assets acquired was less than the purchase price. We may not realize the full value of this goodwill. As such, we evaluate, at least on an annual basis, whether events and circumstances indicate that all or some of the carrying value of goodwill is no longer recoverable, in which case we would write off the unrecoverable goodwill as a charge against our earnings. Due primarily to changes in the economics of the Specialty Infusion business unit, we recorded a non-cash impairment charge from continuing operations of $79.8 million in goodwill and $0.l million in other intangible assets, respectively, in the third quarter of 2005. We conducted an additional analysis as of December 31, 2005 and, based on our results, no further impairment was identified. We will continue to monitor our goodwill and intangibles for impairment indicators.

As of December 31, 2005, we had goodwill of approximately $36.4 million, or 21% of total assets.

We are highly dependent on our relationships with a limited number of biopharmaceutical and pharmaceutical suppliers, and the loss of any of these relationships could significantly affect our ability to sustain or grow our revenues.

The biopharmaceutical and pharmaceutical industries are susceptible to product shortages. Some of the products that we distribute, such as factor VIII blood-clotting products and IVIG, have experienced shortages in the past due to the inability of suppliers to increase production to meet rising global demand. Although such shortages have ended, demand continues to grow. We are currently experiencing allocation restrictions of IVIG products. Suppliers were unable to increase production to meet rising global demand. We purchase the majority of our supplies of blood-clotting products from five suppliers, who we believe represent substantially all of the production capacity for recombinant factor VIII. In the event that one of these suppliers is unable to continue to supply us with products, it is uncertain whether the remaining suppliers would be able to make up any shortfall resulting from such inability. Our ability to take on additional customers or to acquire other specialty pharmacy or infusion services businesses with significant hemophilia customer bases could be affected negatively in the event we are unable to secure adequate supplies of our products from these suppliers. We have recently been put on allocation of product for IVIG by our largest supplier of IVIG product. Although we believe we will have sufficient supply of IVIG to service our existing customers, we may not be able to increase our market share of providing infusion services related to IVIG. There can be no assurance as to when the allocation for IVIG products will terminate. In addition, it is possible that we will experience price increases for these products. Although we believe the price

increase for these products will be absorbed by our customers, there can be no assurance that we will be successful in passing on any such price increase. If these products, or any of the other drugs or products that we distribute, are in short supply for long periods of time, our business could be harmed.

Some biopharmaceutical suppliers in the specialty pharmacy industry have chosen to limit the number of distributors of their products. If we are not selected as a preferred distributor of one or more of our core products, our business and results of operations could be seriously harmed.

We have identified a trend among some of our suppliers toward the retention of a limited number of preferred distributors to market certain of their biopharmaceutical products. If this trend continues, we cannot be certain that we will be selected and retained as a preferred distributor or can remain a preferred distributor to market these products. Although we believe we can effectively meet our suppliers requirements, there can be no assurance that we will be able to compete effectively with other specialty pharmacy companies to retain our position as a distributor of each of our core products. Adverse developments with respect to this trend could have a material adverse effect on our business and results of operations.

If we fail to cultivate new or maintain established relationships with the physician referral sources, our revenues may decline.

Our success, in part, is dependent upon referrals and our ability to maintain good relationships with physician referral sources. Physicians referring patients to us are not our employees and are free to refer their patients to our competitors. If we are unable to successfully cultivate new referral sources and maintain strong relationships with our current referral sources, our revenues and profits may decline.

If additional providers obtain access to products we handle at more favorable prices, our business could be harmed.

Because we do not receive federal grants under the Public Health Service Act, we are not eligible to participate directly in a federal pricing program administered by the Federal Health Resources and Services Administration s Public Health Service, which allows certain entities with such grants, such as certain hospitals and hemophilia treatment centers, to obtain discounts on drugs, including certain biopharmaceutical products (*e.g.*, hemophilia-clotting factor and IVIG) that represented approximately 47% of our total revenues at December 31, 2005. To the best of our knowledge, these entities benefit by being able to acquire, pursuant to this federal program, products competitive with our at prices lower than our cost for the same products. Our customers, where eligible, may elect to obtain hemophilia-clotting factor, or other products, from such lower-cost entities, which could result in a reduction of revenue to us.

Recent investigations into reporting of average wholesale prices could reduce our pricing and margins.

Many government payors, including Medicare (in 2004) and many state Medicaid programs, as well as a number of private payors, pay us directly or indirectly based upon a drug s AWP. Most of our Specialty Infusion business unit s revenues result from reimbursement methodologies based on the AWP of our products. The AWP for most drugs is compiled and published by third-party price reporting services, such as First DataBank, Inc., from information provided by manufacturers and/or wholesalers. Various federal and state government agencies have been investigating whether the published AWP of many drugs, including some that we distribute and sell, is an appropriate or accurate measure of the market price of the drugs. There are also several lawsuits pending against various drug manufacturers in connection with the appropriateness of the manufacturers AWP for a particular drug(s). These government investigations and lawsuits involve allegations that manufacturers reported artificially inflated AWPs of various drugs to third-party price reporting services, which, in turn, reported these prices to its subscribers, including many state Medicaid agencies who then included these AWPs in the state s reimbursement policies.

Moreover, as discussed above, as a result of MMA, Medicare reimbursement for many of the products we distribute, including most physician-administered drugs and biologicals, was lowered to 80-85% of AWP effective January 1, 2004. Although this 2004 change did not affect Medicare reimbursement for blood-clotting factor products, which continued to be reimbursed at 95% of AWP in 2004, effective January 1, 2005, the Medicare reimbursement methodology for blood-clotting factor products changed from an AWP-based system to a system based upon ASP (plus, in the case of hemophilia products, 6% plus an additional administrative fee most recently proposed by CMS to be $0.14 per unit), which has lowered Medicare reimbursement. It is possible that states and/or commercial payors may adopt the new Medicare reimbursement methodology. While we cannot predict the eventual results of any law changes, government proposals, investigations or lawsuits, if government or private payors revise their pricing based on

new methods of calculating AWP for products we supply, or implement reimbursement methodology based on a value other than AWP, this could have a material adverse effect on our business, financial condition and results of operations.

A reduction in the demand for our products and services could result in our reducing the pricing and margins on certain of our products.

A number of circumstances could reduce demand for our products and services, including:

customer shifts to treatment regimens other than those we offer;

new treatments or methods of delivery of existing drugs that do not require our specialty products and services;

the recall of a drug or adverse reactions caused by a drug;

the expiration or challenge of a drug patent;

competing treatment from a new drug, a new use of an existing drug or genetic therapy;

drug companies ceasing to develop, supply and generate demand for drugs that are compatible with the services we provide;

drug companies stopping outsourcing the services we provide or failing to support existing drugs or develop new drugs;

governmental or private initiatives that would alter how drug manufacturers, health care providers or pharmacies promote or sell products and services;

the loss of a managed care or other payor relationship covering a number of high-revenue customers; or

the cure of a disease w service.

Our business involves risks of professional, product and hazardous substance liability, and any inability to obtain adequate insurance may adversely affect our business.

The provision of health services entails an inherent risk of professional malpractice, regulatory violations and other similar claims. Claims, suits or complaints relating to health services and products provided by physicians, pharmacists or nurses in connection with our Specialty Infusion and Wound Care Management businesses may be asserted against us in the future.

Our operations involve the handling of bio-hazardous materials. Our employees, like those of all companies that provide services dealing with human blood specimens, may be exposed to risks of infection from AIDS, hepatitis and other blood-borne diseases if appropriate laboratory practices are not followed. Although we believe that our safety procedures for handling and disposing of such materials comply with the standards prescribed by state and federal regulations, we cannot completely eliminate the risk of accidental infection or injury from these materials. In the event of such an accident, we could be held liable for any damages that result, and such liability could harm our business.

Our operations expose us to product and professional liability risks that are inherent in managing the delivery of wound care services and the provision and marketing of biopharmaceutical and pharmaceutical products. We currently maintain professional and product liability insurance coverage of $15.0 million in the aggregate. Because we cannot predict the nature of future claims that may be made, there can be no assurance that the coverage limits of our insurance would be adequate to protect us against any potential claims, including claims based upon the transmission of infectious diseases, contaminated products, negligent services or otherwise. In addition, we may not be able to obtain or maintain professional or product liability insurance in the future on acceptable terms, if at all, or with adequate coverage against potential liabilities.

We rely on key community-based representatives whose absence or loss could harm the business.

The success of our Specialty Infusion business unit depends upon our ability to retain key employees known as community-based representatives, and the loss of their services could adversely affect our business and prospects. Our community-based representatives are our chief contacts and maintain the primary relationship with our customers, and the loss of a single community-based representative could result in the loss of a significant number of customers. We do not have key person insurance on any of our community-based representatives. In addition, our success depends upon, among other things, the successful recruitment and retention of qualified personnel, and we may not be able to retain all of our key management personnel or be successful in recruiting additional replacements should that become necessary. On October 21, 2005, six hemophilia service representatives in our Specialty Infusion business unit resigned. We estimate that the patients serviced by these employees represent approximately $25.0 million of revenue annually. While it is not certain that we will lose the full $25.0 million of revenue, it is likely that we will experience a significant decrease in revenue as a result of these resignations. We may experience the loss of other hemophilia services representatives in the future which could adversely affect our business and prospects.

Our inability to maintain a number of important contractual relationships could adversely affect our operations.

Substantially all of the revenues of our Wound Care Management operations are derived from management contracts with acute care hospitals. At December 31, 2005, we had 109 management contracts (103 operating and 6 contracted). The contracts generally have initial terms of three to five years, and many have automatic renewal terms unless specifically terminated. The contracts often provide for early termination either by the client hospital if specified performance criteria are not satisfied, or by us under various other circumstances. Historically, some contracts have expired without renewal, and others have been terminated by us or the client hospital for various reasons prior to their scheduled expiration. During the year ended December 31, 2005, two hospital contracts expired without renewal, and an additional four hospital contracts were terminated by the client hospital prior to the scheduled expiration. Hospital contracts have been terminated for reasons such as hospital financial difficulties, Medicare reimbursement changes which reduced hospital revenues and the desire of the hospital to exit the business or manage it on its own. Our continued success is subject to, among other things, our ability to renew or extend existing management contracts and obtain new management contracts. Any hospital may decide not to continue to do business with us following expiration of its management contract, or earlier if such management contract is terminable prior to expiration. In addition, any changes in the Medicare program or third-party reimbursement levels which generally have the effect of limiting or reducing reimbursement levels for health services provided by programs managed by us could result in the early termination of existing management contracts and could adversely affect our ability to renew or extend existing management contracts and to obtain new management contracts. The termination or non-renewal of a material number of management contracts could harm our business.

Our business will suffer if we lose relationships with payors.

We are partially dependent on reimbursement from non-governmental payors. Many payors seek to limit the number of providers that supply drugs to their enrollees. From time to time, payors with whom we have relationships require that we and our competitors bid to keep their business and, therefore, due to the uncertainties involved in any bidding process, we either may not be retained or may have to reduce our margins to retain business. The loss of a significant number of payor relationships, or an adverse change in the financial condition of a significant number of payors, could result in the loss of a significant number of patients and harm our business.

Changes in reimbursement rates which cause reductions in the revenues of our operations have adversely affected our Wound Care Management business unit.

As a result of the Balanced Budget Act of 1997, CMS implemented the Outpatient Prospective Payment System for most hospital outpatient department services furnished to Medicare patients beginning August 2000, under which a predetermined rate is paid to each hospital for clinical services rendered, regardless of the hospital s cost. We believe the new payment system does not provide comparable reimbursement for services previously reimbursed on a reasonable cost basis, and we believe the payment rates for many services are insufficient for many of our hospital customers, resulting in revenue and income shortfalls for the Wound Care Center® programs we manage on behalf of the hospitals. As a result, during 2004, we renegotiated and modified many of our management contracts related to our Wound Care Management business unit, which has resulted in reduced revenue and income to us from those

modified contracts and, in numerous cases, contract termination. We expect that contract renegotiation and modification with many of our hospital customers will continue, and this could result in reduced revenues and income to us from those contracts and even contract terminations. These results could harm our business.

The Wound Care Center® programs managed by our Wound Care Management business unit on behalf of acute care hospitals are generally treated as provider based entities for Medicare reimbursement purposes. This designation is required for the hospital-based program to be covered under the Medicare outpatient reimbursement system. Although we believe that the programs we manage substantially meet the current criteria to be designated provider based entities, a widespread denial of such designation could harm our business.

We are subject to pricing pressures and other risks involved with third-party payors.

In recent years, competition for patients, efforts by traditional third-party payors to contain or reduce health care costs, and the increasing influence of managed care payors, such as health maintenance organizations, have resulted in reduced rates of reimbursement. Commercial payors, such as managed care organizations and traditional indemnity insurers, increasingly are requesting fee structures and other arrangements providing for health care providers to assume all or a portion of the financial risk of providing care. Changes in reimbursement policies of governmental third-party payors, including policies relating to Medicare, Medicaid and other federally funded programs, could reduce the amounts reimbursed to our customers for our products and, in turn, the amount these customers would be willing to pay for our products and services, or could directly reduce the amounts payable to us by such payors. The lowering of reimbursement rates, increasing medical review of bills for services and negotiating for reduced contract rates could harm our business. Pricing pressures by third-party payors may continue, and these trends may adversely affect our business.

Also, continued growth in managed care and capitated plans have pressured health care providers to find ways of becoming more cost competitive. Managed care organizations have grown substantially in terms of the percentage of the population they cover and in terms of the portion of the health care economy they control. Managed care organizations have continued to consolidate to enhance their ability to influence the delivery of health care services and to exert pressure to control health care costs. A rapid increase in the percentage of revenue derived from managed care payors or under capitated arrangements without a corresponding decrease in our operating costs could harm our business.

There is substantial competition in the specialty pharmacy, home infusion and wound care services industries, and we may not be able to compete successfully.

Our Specialty Infusion business unit faces competition from other specialty infusion, specialty pharmacy, home infusion and disease management entities, general health care facilities and service providers, biopharmaceutical companies, pharmaceutical companies as well as other competitors. Many of these companies have substantially greater capital resources, marketing staffs and experience in commercializing products and services than we have, and may be able to obtain better pricing from suppliers of products we purchase and distribute. The principal competition with our Wound Care Management business unit consists of specialty clinics that have been established by some hospitals or physicians. Additionally, there are some private companies which provide wound care services through a hyperbaric oxygen therapy program format. Furthermore, recently developed technologies, or technologies that may be developed in the future, are or may be the basis for products which compete with our specialty infusion business or chronic wound care services. We may not be able to enter into co-marketing arrangements with respect to these products or maintain pricing arrangements with suppliers that preserve margins, and we may not be able to compete effectively against such companies in the future.

If we are unable to effectively adapt to changes in the health care industry, our business will be harmed.

Political, economic and regulatory influences are subjecting the health care industry in the United States to fundamental change. We anticipate that Congress and state legislatures may continue to review and assess alternative health care delivery and payment systems and may in the future propose and adopt legislation effecting fundamental changes in the health care delivery system as well as changes to Medicare s coverage and payments of the drugs and services we provide.

It is possible that legislation enacted by Congress or state legislatures could harm our business or could change the operating environment of our targeted customers (including hospitals and managed care organizations). Health care industry participants may react to such legislation by curtailing or deferring expenditures and initiatives, including those relating to our programs and services. It is possible that the changes to the Medicare program reimbursement may serve as precedent to possible changes in other payors reimbursement policies in a manner adverse to us. In addition, such legislation and regulatory changes could encourage integration or reorganization of the health care delivery system in a manner that could materially and adversely affect our ability to compete or to continue our operations without substantial changes.

There are a number of state and federal laws and regulations that apply to our operations which could harm our business.

A number of state and federal laws and regulations apply to, and could harm, our business. These laws and regulations include, among other things, the following:

The federal anti-kickback law prohibits the offering or solicitation of remuneration in return for the referral of patients covered by almost all governmental programs, or the arrangement or recommendation of the purchase of any item, facility or service covered by those programs. HIPAA created new violations for fraudulent activity applicable to both public and private health care benefit programs and prohibits inducements to Medicare or Medicaid eligible patients to influence their decision to seek specific items and services reimbursed by the government or to choose a particular provider. The potential sanctions for violations of these laws include significant fines, exclusion from participation in Medicare and Medicaid and criminal sanctions. Although some safe harbor regulations attempt to clarify when an arrangement may not violate the anti-kickback law, our business arrangements and the services we provide may not fit within these safe harbors. Failure to satisfy a safe harbor requires further analysis of whether the parties violated the anti-kickback law. In addition to the anti-kickback law, many states have adopted similar kickback and/or fee-splitting laws, which can affect the financial relationships we may have with our customers, physicians, vendors, other retail pharmacies and patients. The finding of a violation of the federal laws or one of these state laws could harm our business.

HHS issued final regulations implementing the Administrative Simplification Provisions of HIPAA concerning the maintenance, transmission, and security of individually identifiable health information. The privacy regulations, with which compliance was required as of April 2003, impose on covered entities (including hospitals, pharmacies and other health care providers) significant new restrictions on the use and disclosure of individually identifiable health information. The security regulations, with which compliance was required as of April 2005, impose on covered entities certain administrative, technical, and physical safeguard requirements with respect to individually identifiable health information maintained or transmitted electronically. The regulations establishing electronic transaction standards that all health care providers must use when electronically submitting or receiving individually identifiable health information in connection with certain health care transactions became effective October 2002, but Congress extended the compliance deadline until October 2003 for organizations, such as ours, that submitted a request for an extension. As a result of these HIPAA regulations, we have taken the appropriate actions to ensure that patient data kept on our computer networks are in compliance with these regulations. We believe that we are substantially in compliance with the HIPAA electronic standards and are capable of delivering HIPAA standard transactions electronically. In addition, if we choose to distribute drugs through new distribution channels, such as the Internet, we will have to comply with government regulations that apply to those distribution channels, which could harm our business. In addition to HIPAA, a number of states have adopted laws and/or regulations applicable to the use and

disclosure of patient health information that are more stringent than comparable provisions under HIPAA. The finding of a violation of HIPAA or one of these state laws could harm our business.

The Ethics in Patient Referrals Act of 1989, as amended, commonly referred to as the Stark Law, prohibits physician referrals to entities with which the physician or his or her immediate family members have a financial relationship and prohibits the entity receiving the referral from presenting a claim to Medicare or Medicaid programs for services furnished under the referral. On March 26, 2004, CMS issued the second phase of its final regulations, addressing physician self-referrals, which became effective July 24, 2004. A violation of the Stark Law is punishable by civil sanctions, including significant fines, a denial of payment or a requirement to refund certain amounts collected, and exclusion from participation in

Medicare and Medicaid. A number of states have adopted laws and/or regulations that contain provisions that track, or are otherwise similar to, the Stark Law. The finding of a violation of the Stark Law or one or more of these state laws could harm our business.

State laws prohibit the practice of medicine, pharmacy and nursing without a license. To the extent that we assist patients and providers with prescribed treatment programs, a state could consider our activities to constitute the practice of medicine. Our nurses must obtain state licenses to provide nursing services to some of our patients. In addition, in some states, coordination of nursing services for patients could necessitate licensure as a home health agency and/or could necessitate the need to use licensed nurses to provide certain patient-directed services. If we are found to have violated those laws, we could face civil and criminal penalties and be required to reduce, restructure or even cease our business in that state.

Pharmacies (retail, mail-order and wholesale) as well as pharmacists often must obtain state licenses to operate and dispense drugs. Pharmacies must also obtain licenses in some states in order to operate and provide goods and services to residents of those states. In addition, our pharmacies may be required by the federal Drug Enforcement Agency, as well as by similar state agencies, to obtain registration to handle controlled substances, including certain prescription drugs, and to follow specified labeling and recordkeeping requirements for such substances. If we are unable to maintain our pharmacy licenses, or if states place burdensome restrictions or limitations on non-resident pharmacies, this could limit or otherwise affect our ability to operate in some states, which could harm our business.

Federal and state investigations and enforcement actions continue to focus on the health care industry, scrutinizing a wide range of items such as joint venture arrangements, referral and billing practices, product discount arrangements, home health care services, dissemination of confidential patient information, promotion of off-label drug indications use, clinical drug research trials and gifts for patients or referral sources. From time to time, and like others in the health care industry, we receive requests for information from government agencies in connection with their regulatory or investigative authority.

We are subject to federal and state laws prohibiting entities and individuals from knowingly and willfully making claims to Medicare and Medicaid and other governmental programs and third-party payors that contain false or fraudulent information. The federal False Claims Act encourages private individuals to file suits on behalf of the government against health care providers such as us. As such suits are generally filed under seal with a court to allow the government adequate time to investigate and determine whether it will intervene in the action, the implicated health care providers are often unaware of the suit until the government has made its determination and the seal is lifted. Violations or alleged violations of such laws, and any related lawsuits, could result in significant financial or criminal sanctions (including treble damages) or exclusion from participation in the Medicare and Medicaid programs. Some states also have enacted statutes similar to the False Claims Act which may provide for large penalties, substantial fines and treble damages if violated.

There is a delay between our performance of services and our reimbursement.

Billing and collection for our services is a complex process requiring constant attention and involvement by senior management and ongoing enhancements to information systems and billing center operating procedures. The health care industry is characterized by delays that typically range from three to nine months from the time services are provided to the time when the reimbursement or payment for these services is received, which makes working capital management, including prompt billing and collection, an important factor in our operating results and liquidity. Trends in the industry may further extend the collection period and impact our working capital.

We recognize revenues when we provide services to patients. However, our ability to collect these receivables depends, in part, on our submissions to payors of accurate and complete documentation. In order for us to bill and receive payment for our services, the physician and the patient must provide appropriate billing information. Failure to meet the billing requirements of the different payors could have a significant impact on our revenues, profitability and cash flow. If we are unable to collect our accounts receivable on a timely basis, our revenues, profitability and cash flow could be adversely affected.

We rely heavily on a limited number of shipping providers, and our business could be harmed if their rates are increased or our providers are unavailable.

A significant portion of our revenues result from the sale of drugs we deliver to our patients, and a significant amount of our products are delivered by overnight mail or courier or through retail pharmacies. The costs incurred in shipping are not passed on to our customers and, therefore, changes in these costs directly impact our margins. We depend heavily on these outsourced shipping services for efficient, cost-effective delivery of our products. The risks associated with this dependence include: any significant increase in shipping rates; strikes or other service interruptions by these carriers; and spoilage of high-cost drugs during shipment since our drugs often require special handling, such as refrigeration.

If we do not maintain effective and efficient information systems, our operations may be adversely affected.

Our operations depend, in part, on the continued and uninterrupted performance of our information systems. Failure to maintain reliable information systems or disruptions in our information systems could cause disruptions in our business operations, including billing and collections, loss of existing patients and difficulty in attracting new patients, patient and payor disputes, regulatory problems, increases in administrative expenses or other adverse consequences, any or all of which could have a material adverse effect on our operations.

Provisions of our articles of incorporation and Minnesota law may make it more difficult for a person to receive a change-in-control premium.

Our Board s ability to designate and issue up to 10 million shares of preferred stock and issue up to 50 million shares of common stock could adversely affect the voting power of the holders of common stock, and could have the effect of making it more difficult for a person to acquire, or could discourage a person from seeking to acquire, control of the Company. If this occurred, a person could lose the opportunity to receive a premium on the sale of his or her shares in a change of control transaction.

In addition, the Minnesota Business Corporation Act contains provisions that would have the effect of restricting, delaying or preventing altogether certain business combinations with any person who becomes an interested stockholder. Interested stockholders include, among others, any person who, together with affiliates and associates, acquires 10% or more of a corporation s voting stock in a transaction which is not approved by a duly constituted committee of the Board of the corporation. These provisions could also limit a person s ability to receive a premium in a change of control transaction.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our headquarters are currently located in Nashua, New Hampshire. We lease this approximately 26,000 square foot facility under a lease which expires in February 2012. Additionally, through our Specialty Infusion business unit, we lease office, pharmacy and warehouse space in various states. We have leases for our 46 branch pharmacy locations, totaling approximately 247,000 square feet. We believe that our facilities are adequate and suitable for our operation. Our Wound Care Management business unit operates hospital outpatient Wound Care Center programs in facilities which are owned or leased by the hospitals.

ITEM 3. LEGAL PROCEEDINGS

In the normal course of our business, we may be involved in lawsuits, claims, and investigations, including any arising out of services or products provided by or to our operations, personal injury claims and employment disputes, the outcome of which, in the opinion of management, will not have a material adverse effect on our financial position, cash flows or results of operations.

On March 27, 2006, the Petition Date, we filed a Prepackaged Joint Plan of Reorganization under Chapter 11 of the Bankruptcy Code in the United States Bankruptcy Court for the Southern District of New York. The Chapter 11 proceedings are further discussed above and in Note 1 of Notes to Consolidated Financial Statements included elsewhere in this Annual Report on Form 10-K. The Chapter 11 proceedings were entered into in response to various issues that have negatively affected our liquidity and our ability to service our debt obligations.

Material pending legal proceedings, other than the Chapter 11 proceedings above and other than ordinary, routine litigation incidental to the business, to which we became or were a party during the year ended December 31, 2005, or subsequent thereto but before the filing of this report, are summarized below.

Apex Therapeutic Care Litigation

As previously disclosed, on October 26, 2005, we commenced litigation in the United States District Court for the Central District of California, entitled Curative Health Services, Inc. vs. James H. Williams, et al., against former stockholders of Apex alleging, among other things, that stockholders of Apex made material misrepresentations in connection with their sale of Apex stock to Curative in 2002. As part of the action, in addition to seeking $60.0 million in compensatory damages and available punitive damages, we are disputing our obligation to make further payments under an amended and restated promissory note, dated May 30, 2002, made in favor of the former stockholders in connection with the acquisition of Apex. Prior to commencement of the action, Curative sent a letter to the representative of the former stockholders indicating that Curative would not be making the installment payment due on September 30, 2005 or any further payments pending resolution of this dispute. The stockholders representative responded with a notice on October 18, 2005 declaring an event of default under the above-referenced note and an acceleration of payment of the outstanding principal balance under the note in the amount of approximately $1.5 million. This event did not cause a default under, or acceleration of, any other obligations of Curative.

DHS Audit

Two of the Company s subsidiaries, Apex and eBioCare, might be subject to potential indemnification liabilities to three independent retail pharmacies that previously did business with Curative. The indemnification claims are in connection with an audit conducted by the Department of Health Services of the State of California related to the pharmacies medical billing for clotting factor supplied to the pharmacies by Apex and eBioCare, and the pharmacies medical billing for the anti-inhibitor product FEIBA supplied to the pharmacies by Apex and eBioCare. While liability with respect to these claims is uncertain at this time, Apex and eBioCare believe that some amount of monetary loss is reasonably possible if the pharmacies assert and prevail on indemnification claims. Apex and eBioCare estimate that the range of loss may be anywhere from $0 to $39.3 million. As the amount of potential exposure cannot be estimated at this time, no related loss provision has been accrued in the consolidated financial statements as of December 31, 2005.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

None.

PART II

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

The Company s common stock was traded on the NASDAQ National Market System under the symbol CURE. As previously reported in a Form 8-K filed on February 13, 2006, due to its continuing failure to satisfy the minimum aggregate market value of publicly held shares requirement for continued listing, the Company s common stock was delisted from the NASDAQ National Market System effective February 21, 2006. Since that date, Curative s existing common stock has been quoted in the over-the-counter market.

The following table sets forth the range of high and low sales prices of the Company s common stock as quoted on the NASDAQ National Market System prior to delisting:

2005	High	Low
Fourth Quarter	$ 0.92	$ 0.15
Third Quarter	3.48	0.94
Second Quarter	3.48	1.44
First Quarter	7.00	2.82

2004	High	Low
Fourth Quarter	$ 6.91	$ 4.79
Third Quarter	8.63	5.22
Second Quarter	13.74	8.58
First Quarter	14.22	11.82

The closing sale price for the common stock as quoted on the NASDAQ National Market System on February 17, 2006 was $0.21.

Holders. As of March 10, 2006, there were 140 holders of record of the Company s common stock.

Dividends. The Company has not paid any cash dividends since its inception, nor does it currently intend to pay cash dividends in the foreseeable future. The Company intends to retain all earnings, if any, for use in its business operations. The Company has entered into an indenture pursuant to its Senior Notes. Under this indenture, the Company cannot, directly or indirectly, make any dividend payment if at the time of such payment:

1. there is a default under the Senior Notes or a default under those Notes shall occur as a consequence of such payment;

2. the Company cannot incur $1.00 of additional indebtedness under the Coverage Ratio Exception (as defined in the indenture); or

3. the dividend, when added to the aggregate amount of all other restricted payments (as defined in the indenture) made after April 23, 2004, exceeds a certain Restricted Payments Basket (as defined in the indenture).

The Company is currently in default under the Senior Notes and so is prohibited from making any dividend payments.

Recent sales of unregistered securities. There were no unregistered securities sold by the Company during the fiscal year ended December 31, 2005.

Issuer purchases of equity securities. The Company did not repurchase any of its common stock during the fiscal quarter ended December 31, 2005.

ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

The following should be read in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations, as well as the consolidated financial statements and notes thereto contained elsewhere in this Annual Report on Form 10-K. Financial Highlights and Results of Operations should be read together with the accompanying Consolidated Financial Statements and Notes. The period-to-period comparability of the Company s selected consolidated financial data is affected by its acquisition activity. Please see discussion in the section titled Management s Discussion and Analysis of Financial Condition and Results of Operations - Overview.

Five year selected consolidated financial data of Curative Health Services, Inc. and Subsidiaries for the years ended December 31 is as follows (in thousands, except per share data):

	2005(1)	2004(1)	2003(1)	2002	2001
Statements of Operations Data:					
Total revenues	$ 261,059	$ 224,980	$ 163,494	$ 139,229	$ 81,638
Costs and operating expenses:					
Costs of product sales and services	206,191	168,930	102,465	89,297	55,666
Selling, general and administrative	55,702	50,042	40,995	26,401	51,466
Goodwill and intangible asset impairment	77,608	133,969			
Total costs and operating expenses	339,501	352,941	143,460	115,698	107,132
(Loss) income from operations	(78,442)	(127,961)	20,034	23,531	(25,494)
Interest (expense) income, net	(25,468)	(15,726)	(2,280)	(1,111)	816
Other income (expense), net	712	(1,081)	2,327	1,907	
(Loss) income from continuing operations	(103,198)	(144,768)	20,081	24,327	(24,678)
Income tax (benefit) provision	(3,415)	(3,949)	7,909	9,682	(2,473)
(Loss) income from continuing operations	(99,783)	(140,819)	12,172	14,645	(22,205)
(Less) Income from discontinued operations	(1,809)	(586)	903		
Net (loss) income	$ (101,592)	$ (141,405)	$ 13,075	$ 14,645	$ (22,205)
Per Share Data Basic					
(Loss) income - continuing operations	$ (7.67)	$ (10.89)	$ 0.97	$ 1.30	$ (3.09)
(Loss) Income - discontinued operations	(0.14)	(0.04)	0.07		
Net (loss) income	$ (7.81)	$ (10.93)	$ 1.04	$ 1.30	$ (3.09)
Per Share Data Diluted					
(Loss) income - continuing operations	$ (7.67)	$ (10.89)	$ 0.89	$ 1.20	$ (3.09)
(Loss) income - discontinued operations	(0.14)	(0.04)	0.07		
Net (loss) income	$ (7.81)(2)	$ (10.93)(2)(3)	$ 0.96(2)(3)	$ 1.20	$ (3.09)
Weighted average common shares, basic	13,002	12,932	12,536	11,280	7,193

Weighted average common shares assuming conversions, diluted	13,002	12,932	13,816	12,207	7,193

	2005(1)	2004(1)	2003(1)	2002	2001
Balance Sheet Data:					
Working capital (deficit)	$ (156,875)	$ 50,788	$ 25,468	$ 17,353	$ 2,525
Total assets	169,288	283,784	233,938	186,886	76,439
Long-term liabilities	6,329	215,711	40,906	26,153	6,000
(Accumulated deficit) retained earnings	(212,879)	(111,287)	30,118	17,043	2,398
Stockholders (deficit) equity	(94,333)	4,453	143,720	120,901	36,004

(1) Excludes amounts from discontinued operations for revenues and operating expenses. See Note 5 of Notes to Consolidated Financial Statements.

(2) See Note 18 of Notes to Consolidated Financial Statements for net (loss) income per share calculation.

(3) Weighted average shares used in the above calculations have been corrected for 2004. Such correction resulted in an increase in net loss per share of $.01 for the fourth quarter of 2004, and had no impact on 2003.

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

OVERVIEW

The Company had approximately $213.2 million in outstanding debt as of December 31, 2005, including the $185.0 million of Senior Notes and a $26.3 million revolving credit facility with GECC, and incurred significant losses during 2005 and 2004. In August 2005, the Company announced it had formed a special committee and hired a financial advisor to assist it in evaluating the financial alternatives available given its significant debt and continuing losses. In September 2005, the Company commenced discussions with an Ad Hoc committee representing holders of approximately 80% of the aggregate principal amount of the Senior Notes regarding a possible restructuring of the Senior Notes. In connection with these discussions, the Company elected not to pay the interest payment due on the Senior Notes on November 1, 2005 and instead elected to use the 30-day grace period under the Senior Note indenture. In addition, the Company executed a waiver agreement with GECC for failing to meet the financial covenants of total leverage ratio and senior secured leverage ratio related to its revolving credit facility for the quarter ended September 30, 2005. Additionally, this waiver agreement included a temporary waiver until December 1, 2005 of any default under the credit facility related to the Company s not paying the November 1, 2005 coupon on the Senior Notes for 30 days. On December 1, 2005, the Company entered into a Forbearance Agreement with GECC which provides that, subject to certain conditions, GECC, together with the other lenders under the Existing Credit Facility, which is governed by the Credit Agreement, will forbear from exercising remedies on account of the cross-default under the Credit Agreement arising from the Company s failure to pay interest on the Senior Notes. Subject to certain termination events, including additional events of default under the Credit Agreement, the Forbearance Agreement will expire on June 10, 2006. Under the terms of the Forbearance Agreement, Curative may continue to draw-down under the Credit Agreement as if such existing events of default had not occurred. Upon termination of the Forbearance Agreement, all obligations under the Credit Agreement, together with interest, will be immediately due and payable and the lenders may exercise any rights or remedies thereunder. As of April 5, 2006, our obligations under our Existing Credit Facility with GECC have been paid in full in connection with the interim order of the Bankruptcy Court authorizing the DIP Financing described below. The DIP Financing remains subject to approval by the Bankruptcy Court on a final basis. If the Bankruptcy Court does not enter a final order approving the DIP Financing, the Existing Credit Facility will be reinstated.

As a result of these developments, all of the Company s outstanding debt is in default and has been classified as current in the accompanying financial statements. These conditions raise substantial doubt about the Company s ability to continue as a going concern (see Note 2 of Notes to Consolidated Financial Statements).

Curative operates a Specialty Infusion business unit and a Wound Care Management business unit to deliver high-quality care and positive clinical outcomes for patients experiencing serious acute or chronic medical conditions.

Through its Specialty Infusion business unit, the Company provides intravenous and injectable biopharmaceutical and compounded pharmaceutical products and comprehensive infusion services to patients with chronic and critical disease states. All patient care is delivered through a national footprint of community-based branches. Each local branch has an experienced multidisciplinary team of pharmacists, nurses, reimbursement specialists and patient service representatives who comprehensively manage all aspects of a patient s infusion and related support needs. In its Specialty Infusion operations, the Company purchases biopharmaceutical and other

pharmaceutical products from suppliers and contracts with insurance companies and other payors to provide its services, which include coordination of patient care, 24-hour nursing and pharmacy availability, patient education and reimbursement billing and collection services. The Company s Specialty Infusion revenues are derived primarily from fees paid by the payors under these contracts for the distribution of these biopharmaceutical and other pharmaceutical products and for the injection or infusion services provided. Additional revenues are acquired through biopharmaceutical and pharmaceutical product distribution and support services under contracts with retail pharmacies for which the Company receives related service fees. The products distributed and the injection or infusion therapies offered by Curative are used by patients with chronic or severe conditions such as hemophilia, immune system disorders, chronic or severe infections, nutritionally compromised and other severe conditions requiring nutritional support, cancer, rheumatoid arthritis, hepatitis C and multiple sclerosis. As of December 31, 2005, the Company had approximately 485 payor contracts and provided products or services in approximately 45 states.

The Wound Care Management business unit contracts with hospitals to manage outpatient Wound Care Center® programs that offer a comprehensive range of services and enable the Wound Care Management business unit to provide patient specific wound care diagnosis and treatments on a cost-effective basis. Wound Care Management currently operates two types of Wound Care Center® programs with hospitals: a management model and an under arrangement model, with a primary focus on developing management models.

In the management model, Wound Care Management provides management and support services for a chronic wound care facility owned or leased by the hospital and staffed by employees of the hospital, and generally receives a fixed monthly management fee or a combination of a fixed monthly management fee and a variable case management fee. In the under arrangement model, Wound Care Management provides management and support services, as well as the clinical and administrative staff, for a chronic wound care facility owned or leased by the hospital, and generally receives fees based on the services provided to each patient. In both models, physicians remain independent. Wound Care Management offers assistance in recruiting and provides training in wound care to the physicians and staff associated with the Wound Care Center® programs. As of December 31, 2005, the Wound Care Center® network consisted of 109 outpatient clinics (103 operating and 6 contracted) located on or near campuses of acute care hospitals in approximately 30 states.

CHAPTER 11 BANKRUPTCY PROCEEDINGS

On March 27, 2006, Curative and each of its direct and indirect subsidiaries filed voluntary petitions under chapter 11 of the Bankruptcy Code in the Bankruptcy Court. The Company filed its Chapter 11 Cases to implement and effect the Plan. Prior to commencement of the Chapter 11 Cases, Curative solicited votes to accept or reject the Plan from the holders of the Senior Notes issued by the Company and the holders of known general unsecured claims against the Company as of February 6, 2006. Prior to the commencement of the Chapter 11 Cases, the Company received the requisite votes for the Plan to be confirmable under Section 1129 of the Bankruptcy Code.

The Plan was filed with the Bankruptcy Court on March 27, 2006. The Plan, which is described in more detail under Item 1 under the caption, Planned Reorganization and Chapter 11 Bankruptcy Proceedings, will, if confirmed and consummated, result in the cancellation and discharge of all claims relating to the Senior Notes. Each Senior Noteholder will receive a cash payment of approximately 54.9% of its respective claim related to the Senior Notes, unless a Senior Noteholder was qualified to elect and did elect to receive its pro rata share of certain cash consideration provided in the Plan and the New Curative Common Stock. Holders of existing shares of Old Curative Common Stock and options will not receive any distributions under the Plan and all shares of Old Curative Common Stock and options will be extinguished.

In connection with the reorganization to be effected by the Plan, the Company intends to deregister its existing securities under the Securities Exchange Act of 1934, and become a private company upon its emergence from Chapter 11.

Events Leading to Chapter 11 Cases

Factors Affecting the Company s Liquidity

Since June 2004, Curative has faced various issues that have negatively affected its liquidity and its ability to service its debt obligations. Specifically, and as described in further detail below, Curative has experienced reduced revenue generation as a result of:

- California s modification of its blood-product reimbursement methodology,
- a modification of the federal government s blood-product reimbursement methodology,
- slow maturation of certain new branch locations,
- the resignation of certain customer sales and service representatives, and
- additional future liquidity risks, including potential indemnification claims.

Significant Decrease in Blood-Product Reimbursement

On April 23, 2004, the Company acquired CCS, a leading national provider of specialty infusion pharmaceuticals and related services for a purchase price of $154.2 million, including working capital adjustments of approximately $4.1 million. The acquisition of CCS was financed with a portion of the proceeds obtained from the issuance of the Senior Notes and additional borrowings. See Note 4 of Notes to Consolidated Financial Statements included elsewhere in this Annual Report on Form 10-K.

At the time of the CCS acquisition, a significant portion of the Company s business involved the sale of blood-clotting products by the Company to hemophilia patients who are beneficiaries of Medi-Cal program or other state funded programs for hemophilia patients. These blood products were dispensed directly to patients or through the Company s relationships with third party pharmacies.

In May 2004, California announced that, effective June 1, 2004, California modified its reimbursement methodology for blood-clotting products to ASP (as provided by the manufacturer) plus 20%. This change in California s reimbursement methodology amounted to an approximate 30-40% reduction from the acquisition cost plus 1% methodology previously in effect. The implementation of this reduction in reimbursement from Medi-Cal, and changes in regulations governing such reimbursement, significantly impacted the Company s revenues from the sale of blood-clotting products.

In addition to the 30%-40% decrease in revenue for blood-clotting products generated from Medi-Cal reimbursement, in November 2004, the federal government announced that, effective January 1, 2005, it would modify its reimbursement methodology for blood-clotting products in a manner which would negatively affect the Company s revenues. Prior to January 1, 2005, Curative was able to seek reimbursement from Medicare for blood-clotting products at a rate of 95% of the AWP. After January 1, 2005, Medicare reimbursed for blood-clotting products at a rate of ASP plus 6% plus a $0.14 per unit dispensing fee.

Underperforming Branch Expansion

The Company s overall growth strategy, and its approach to offsetting the decreased revenue resulting from the change in Medi-Cal reimbursement methodology described above, included opening 13 new branches throughout the United States since June 2004. The Company projected that these new branches would quickly enter into the necessary service contracts and other business and patient relationships in the short-term and begin generating positive revenue consistent with historical results. However, for various reasons, including slower than anticipated managed care contract signings, certain of these branches have not matured as quickly as planned and have not generated anticipated revenues.

Resignation of Hemophilia Service Representatives

The success of the Company s Specialty Infusion business unit depends in part upon its ability to retain key employees, referred to as hemophilia service representatives, who service hemophilia patients. The hemophilia service representatives are the chief contacts and maintain the primary relationship with Curative s customers. While the Company has employment agreements with its hemophilia service representatives which, where appropriate, contain covenants not to compete and other restrictive covenants that apply if the hemophilia service representatives cease employment with Curative, the loss of any hemophilia service representatives could result in the loss of a significant number of customers and corresponding revenue from the sale of blood-clotting products to such customers.

On October 21, 2005, six hemophilia service representatives resigned. The Company estimates that the patients serviced by these employees represent approximately $25.0 million of revenue annually. While it is not certain that the Company will lose the full $25.0 million of revenue, it is likely that it will experience a significant decrease in revenue as a result of these resignations. The Company may experience the loss of other hemophilia services representatives in the future which could adversely affect its business and prospects.

Additional Factor Affecting the Company s Liquidity

In addition to the factors adversely affecting the Company s revenue generation described above, its future liquidity may also be affected by the following additional factor:

The Pharmacy Claims. Two of the Company s Apex and eBioCare, might be subject to potential indemnification liabilities to three independent retail pharmacies that previously did business with Curative. The indemnification claims are in connection with an audit conducted by the DHS Audit related to the pharmacies medical billing for clotting factor supplied to the pharmacies by Apex and eBioCare, and the pharmacies medical billing for the anti-inhibitor product FEIBA supplied to the pharmacies by Apex and eBioCare. While liability with respect to these claims is uncertain at this time, Apex and eBioCare believe that some amount of monetary loss is reasonably possible if the pharmacies assert and prevail on indemnification claims. Apex and eBioCare estimate that the range of loss may be anywhere from $0 to $39.3 million. As the amount of potential exposure cannot be estimated at this time, no related loss provision has been accrued in the consolidated financial statements as of December 31, 2005.

DISCONTINUED OPERATIONS

On December 2, 2005, the Company sold certain assets related to its specialty injectable and oral medications business (the Business), including Synagis® (collectively, the Assets Sold) to ProCare Pharmacy, Inc. and ProCare Pharmacy Direct, Inc. (collectively, ProCare) for a total consideration of $1.75 million.

Under the Asset Purchase Agreement between Curative and ProCare, the Company sold and ProCare purchased or assumed certain personal property, licenses, permits, contracts, leases and patient files related to the Business. In addition, ProCare assumed and the Company is no longer

responsible for all liabilities and obligations related to the operation of the Business and the Assets Sold arising after the sale. Also in connection with the sale, the Company closed its branches in Albany, New York; Lake Charles, Louisiana; Birmingham, Alabama; Columbus, Mississippi; and Hurricane, West Virginia. As a result, the Company recorded approximately $0.7 million for facility terminations, $0.6 million in inventory and bad debt reserves, $0.7 million in goodwill and intangible write offs, $0.3 million for severance and vacation payouts related to the termination of 88 employees, $0.1 million in equipment write off costs and $0.2 million in other related costs, for a total cost of $2.6 million.

The Company recorded a pre-tax loss on the sale of approximately $0.9 million which was recorded in the accompanying statements of operations for the year ended December 31, 2005. The results of the discontinued operation are classified as such in a separate component of (loss) income on the accompanying Consolidated Statements of Operations. Excluded from the sale was the Company s accounts receivable related to the Business which had a balance of approximately $1.9 million. The Company expects to collect substantially all of those receivables within one year. Thereafter, the Company will have no continuing cash flows or operations related to the discontinued operation. See Note 5 to Notes to Consolidated Financial Statements.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Management s Discussion and Analysis of Financial Condition and Results of Operations discusses the Company s consolidated financial statements which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these consolidated financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. On an ongoing basis, management evaluates its estimates and judgments, including those related to revenue recognition, bad debts, inventories, income taxes and intangibles. Management bases its estimates and judgments on historical experience and on various other factors that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions. Management believes the following critical accounting policies, among others, affect its more significant judgments and estimates used in the preparation of its consolidated financial statements:

Revenue recognition

The Company s Specialty Infusion business unit s revenues and related accounts receivable are recorded, net of any contractual allowances, when the product is shipped to a patient or physician s office, or when the service is provided. The Company records contractual allowances on a payor-by-payor basis in accordance with its interpretation of contractual terms, applicable regulations or payor requirements. Reimbursement rates may be subject to adjustments by payors that could result in payments that differ from the Company s estimates. Additionally, any health care regulation changes or contract amendments may require the Company to review the estimation process. Curative is reimbursed for the products and services it provides from third-party payors, including managed care organizations and Medicare and Medicaid programs, as well as private payors.

Generally, the Company records any required contractual allowances at the time it records revenue and applies amounts against those allowances when cash is received. This process is completed at the transaction level and on a transaction-by-transaction basis. The Company does not track its contractual reserves by date of service nor does it track the amount of increased or decreased reserve recorded when a transaction is closed out. Therefore, the Company cannot provide an analysis of estimate changes by transaction or year.

On a consolidated basis, the Company had a contractual reserve balance of $1.1 million at the end of 2003, reduced reserves by $7.9 million and added reserves of $7.4 million during 2004, a net decrease of $0.5 million, for a balance of contractual reserves at the end of 2004 of $0.6 million. The increase in the Company s contractual allowance was primarily attributed to the acquisition of Critical Care Systems, Inc. in April of 2004. Additionally, included in the net change for 2004 is an increase of $1.0 million recorded in the second quarter of 2004 related to a retroactive reimbursement change the Company experienced. This was previously disclosed in the Company s Quarterly Report on Form 10-Q for the quarter ended June 30, 2004 and Current Report on Form 8-K filed on August 4, 2004 because of the unique nature of the adjustment. In 2005, the Company reduced reserves by $14.5 million and added reserves of $16.3 million, a net increase of $1.8 million, for a balance of contractual reserves at the end of 2005 of $2.4 million. The increase in the Company s contractual allowance was primarily attributed to the acquisition of Critical Care Systems, Inc. in April of 2004.

The Company s Wound Care Management business unit s revenues are recognized after the management services are rendered and are billed monthly in arrears, thus no contractual allowances are required for this portion of the Company s business.

Trade receivables

Considerable judgment is required in assessing the ultimate realization of receivables, including the current financial condition of the customer, age of the receivable and the relationship with the customer. The Company estimates its allowances for doubtful accounts using these factors. If the financial condition of the Company s customers were to deteriorate, resulting in an impairment of their ability to make payments, additional allowances may be required. In circumstances where the Company is aware of a specific customer s inability to meet its financial obligations (e.g., bankruptcy filings), a specific reserve for bad debts is recorded against amounts due to reduce the receivable to the amount the Company reasonably believes will be collected. For all other customers, the

Company has reserves for bad debt based upon the total accounts receivable balance. As of December 31, 2005, the Company s reserve for accounts receivable was approximately 10% of total receivables. Although the Company believes its reserve for accounts receivable at December 31, 2005 is reasonable, there can be no assurance that additional reserves will not be needed in the future. The recording of any such reserve may have a negative impact on the Company s operating results.

The Company verifies benefits with third-party payors and obtains authorization prior to shipping products or rendering services and, as such, the Company does not have accounts receivable pending approval from third-party payors.

The following table breaks down the Company s gross accounts receivable into approximate percentages by payor group and aging classification as of December 31:

	As of December 31, 2005				
Payor Group	0 90 Days	91 180 Days	181 365 Days	> 365 Days	Total
Commercial and other(1)	43%	8%	9%	10%	70%
Medicaid	9%	2%	2%	3%	16%
Medicare	8%	2%	2%	2%	14%
Self-pay(2)	*	*	*	*	*
Total(3)	60%	12%	13%	15%	100%

	As of December 31, 2004				
Payor Group	0 90 Days	91 180 Days	181 365 Days	> 365 Days	Total
Commercial and other(1)	33%	8%	10%	9%	60%
Medicaid	12%	6%	5%	5%	28%
Medicare	7%	*	2%	3%	12%
Self-pay(2)	*	*	*	*	*
Total(3)	52%	14%	17%	17%	100%

(1) Excludes allowances for contractual adjustments of approximately $2.4 million and $0.6 million as of December 31, 2005 and 2004, respectively.

(2) Self-pay amounts primarily consist of patient co-payments, deductibles and self-pay balances on accounts that have not been paid by the primary payor. The Company considers the patient s potential payment obligation in its evaluation of the allowance for doubtful accounts based on the current financial condition of the customer, age of the receivable and the relationship with the customer.

(3) Amounts are calculated as percent of accounts receivable, and excludes allowances for doubtful accounts of $7.4 million and $3.6 million as of December 31, 2005 and 2004, respectively, which are not specifically tracked by payor group and aging classification.

* Less than 1%.

Inventories

Inventories are carried at the lower of cost or market on a first in, first out basis. Inventories consist of high-cost biopharmaceutical and pharmaceutical products that, in many cases, require refrigeration or other special handling. As a result, inventories are subject to spoilage or shrinkage. On a quarterly basis, the Company performs a physical inventory and determines whether any shrinkage or spoilage adjustments are needed. Although the Company believes its inventories balance at December 31, 2005 is reasonably accurate, there can be no assurance that spoilage or shrinkage adjustments will not be needed in the future. The recording of any such reserve may have a negative impact on the Company s operating results.

Deferred income taxes

The Company accounts for income taxes under Statement of Financial Accounting Standards (SFAS) No. 109, Accounting for Income Taxes, which requires the use of the asset and liability method of accounting for income taxes. Under this method, deferred taxes are determined by calculating the future tax consequences attributable to differences between the financial accounting and tax bases of existing assets and liabilities. A valuation allowance is recorded against deferred tax assets when, in the opinion of management, it is more likely than not that the Company will be able to use the deferred tax assets benefit.

The Company records and periodically reviews its estimated income tax reserves. Income tax reserves are established for exposure items related to various federal and state tax matters. Income tax reserves are recorded when an exposure is identified and when, in the opinion of management, it is probable that a liability has been incurred and the amount of the liability can be estimated. While the Company believes that its income tax reserves are adequate, the settlement of any such exposures at amounts that differ from current reserves may require the Company to materially increase or decrease its income tax reserves.

The Company had approximately $25.3 million in deferred income tax assets at December 31, 2005 (approximately $5.8 million in current assets and $19.5 million in long-term assets) and approximately $5.9 million in deferred income tax liabilities. The Company has a full valuation allowance against its net deferred tax assets based on the uncertainty of recovery.

Goodwill and intangibles

Goodwill represents the excess of purchase price over the fair value of net assets acquired. Intangibles consist of separately identifiable intangibles, such as payor contracts, pharmacy and customer relationships and covenants not to compete. The Company accounts for goodwill and intangible assets in accordance with SFAS No. 142, Goodwill and Other Intangible Assets, which requires goodwill and intangible assets with indefinite lives to not be amortized but rather to be reviewed annually, or more frequently if impairment indicators arise, for impairment. Separable intangible assets that are not deemed to have an indefinite life are amortized over their useful lives. In assessing the recoverability of the Company s goodwill and intangibles, the Company must make assumptions regarding estimated future cash flows and other factors to determine the fair value of the respective assets. Due primarily to unfavorable changes in the economics of the Specialty Infusion business unit, the Company recorded non-cash impairment charges from continuing operations of $77.5 million in goodwill and $138 thousand in other intangible assets during the third quarter of 2005 and $133.9 million in goodwill and $68 thousand in other intangible assets during the fourth quarter of 2004 (see Note 6 of Notes to Consolidated Financial Statements). The Company conducted an additional analysis as of December 31, 2005 and, based on those results, no further impairment was identified. The fair value of the Specialty Infusion business unit was estimated by performing a discounted cash flows analysis for the reporting unit. The Company will continue to monitor its goodwill and intangibles for impairment indicators which include, among others, the Company s performance versus its forecast, changes in contracts or reimbursement by payors and critical personnel departures.

KEY PERFORMANCE INDICATORS

The following provides a summary of some of the key performance indicators that may be used to assess the Company s results of operations. These comparisons, which exclude amounts from discontinued operations (see Note 5), are not necessarily indicative of future results (dollars in thousands).

	2005	2004	$ Change	% Change	2004	2003	$ Change	% Change
Specialty Infusion revenues	$ 232,169	$ 198,055	$ 34,114	17%	$ 198,055	$ 134,596	$ 63,459	47%
Wound Care Management revenues	28,890	26,925	1,965	7%	26,925	28,898	(1,973)	(7)%
Total revenues	$ 261,059	$ 224,980	$ 36,079	16%	$ 224,980	$ 163,494	$ 61,486	38%
Specialty Infusion revenues to total	89%	88%			88%	82%		
Wound Care Management revenues to total	11%	12%			12%	18%		
Total	100%	100%			100%	100%		
Specialty Infusion gross margin	$ 38,963	$ 41,201	$ (2,238)	(5)%	$ 41,201	$ 45,355	$ (4,154)	(9)%
Wound Care Management gross margin	15,905	14,849	1,056	7%	14,849	15,674	(825)	(5)%
Total gross margin	$ 54,868	$ 56,050	$ (1,182)	(2)%	$ 56,050	$ 61,029	$ (4,979)	(8)%
Specialty Infusion gross margin %	17%	21%			21%	34%		
Wound Care Management gross margin %	55%	55%			55%	54%		
Total gross margin %	21%	25%			25%	37%		
Specialty Infusion SG&A	$ 27,262	$ 17,858	$ 9,404	53%	$ 17,858	$ 14,100	$ 3,758	27%
Wound Care Management SG&A	3,754	3,971	(217)	(5)%	3,971	4,641	(670)	(14)%
Corporate SG&A	17,367	18,267	(900)	(5)%	18,267	15,502	2,765	18%
Charges(1)	7,319	9,946	(2,627)	(26)%	9,946	6,752	3,194	47%
Total SG&A	$ 55,702	$ 50,042	$ 5,660	11%	$ 50,042	$ 40,995	$ 9,047	22%
Goodwill and intangible asset impairment	$ 77,608	$ 133,969	$ (56,361)	(42)%	$ 133,969	$	$ 133,969	100%
Operating margin (deficit)	$ (78,442)	$ (127,961)	49,519	(39)%	$ (127,961)	$ 20,034	$ (147,995)	(739)%
Operating margin (deficit) %	(30)%	(57)%			(57)%	12%		

(1) The Company s charges are discussed under Results of Operations - *Selling, General and Administrative.*

RESULTS OF OPERATIONS

Fiscal Year 2005 vs. Fiscal Year 2004

Revenues. The Company s revenues increased $36.1 million, or 16%, to $261.1 million for the fiscal year ended December 31, 2005 compared to $225.0 million for the fiscal year ended December 31, 2004. The increase in

revenues for 2005 was the result of the April 2004 acquisition of CCS, offset by a reduction in hemophilia revenue related to reduced reimbursement from California state programs.

Product revenues, attributed entirely to the Specialty Infusion business unit, increased $34.1 million, or 17%, to $232.2 million in 2005 from $198.1 million in 2004. The increase in product revenues for the twelve-month period was primarily attributable to the 2004 acquisition of CCS, offset by a reduction in hemophilia revenue related to the reduced reimbursement from California state programs. As a percentage of Specialty Infusion s revenues, hemophilia revenues accounted for approximately 42% for the year ended December 31, 2005.

Service revenues, attributed entirely to the Wound Care Management business unit, increased $2.0 million, or 7%, to $28.9 million in 2005 from $26.9 million in 2004. During 2005, the Company signed 17 new Wound Care Management contracts and 6 contracts were terminated.

Cost of Product Sales. Cost of product sales, attributed entirely to the Specialty Infusion business unit, increased $36.4 million, or 23%, to $193.2 million in 2005 compared to $156.9 million in 2004. The increase in cost of product sales was primarily attributable to the 2004 acquisition of CCS and increased costs for IVIG products. As a percentage of product revenues, cost of product sales in 2005 was 83% compared to 79% in 2004. The dollar and percentage increases for 2005 were primarily attributable to the acquisition of CCS which resulted in a reduction of the percentage of the Company s revenues derived from hemophilia products, which have a lower product cost as a percentage of revenue, as well as the reduction in hemophilia revenue related to the reduced reimbursement from California state programs.

Cost of Services. Cost of services, attributed entirely to the Wound Care Management business unit, increased $0.9 million, or 8%, to $13.0 million in 2005 from $12.1 million in 2004. As a percentage of service revenues, cost of services was flat at 45% in 2005 and 2004.

Gross Margin. Gross margin decreased $1.2 million, or 2%, to $54.9 million in 2005 from $56.0 million in 2004. Specialty Infusion s gross margin declined to $39.0 million in 2005 from $41.2 million in 2004, a decrease of $2.2 million, or 5%. As a percentage of its revenues, Specialty Infusion s gross margin was 17% in 2005 as compared to 21% in 2004. The decreases in gross margin dollars and percentage for the year ended December 31, 2005 were attributed to lower average revenue per unit for hemophilia products as a result of changes in reimbursement rates, lower average revenue per unit for IVIG products at pharmacies operating before the CCS acquisition due to a higher mix of managed care business and a higher product cost. These decreases were partially offset by the inclusion of the gross margin from the CCS acquisition.

Wound Care Management s gross margin increased 7% to $15.9 million in 2005 compared to $14.8 million in 2004. As a percentage of its revenues, Wound Care Management s gross margin was flat at 55% in 2005 and 2004.

Selling, General and Administrative. Selling, general and administrative expenses increased by $5.7 million, or 11%, to $55.7 million in 2005 compared to $50.0 million in 2004 and consisted of $27.3 million related to the Specialty Infusion business unit, $3.7 million related to the Wound Care Management business unit, $17.4 million related to corporate services and $7.3 million in charges related to the Company s corporate reorganization and financial advisory fees. The increase in selling, general and administrative expenses of $5.7 million was primarily due to the inclusion of CCS s results for a full year in 2005, offset by the charges of $7.3 million in 2005 compared to $9.9 million in 2004, or $2.6 million. The charges incurred during 2005 related to the corporate office relocation and financial restructuring advisory and legal fees. As a percentage of total Company revenues, selling, general and administrative expenses were 21% in 2005 compared to 22% in 2004.

Goodwill Impairment. During the third quarter of 2005, the Company conducted an interim impairment test related to the carrying values of goodwill and other intangible assets, attributed entirely to the Specialty Infusion business unit, in accordance with SFAS No. 142 and SFAS No. 144, respectively. Based on the results of this evaluation, in the third quarter of 2005, the Company recorded non-cash impairment charges from continuing operations of $77.5 million in

goodwill and $0.1 million in other intangible assets related to the Specialty Infusion business unit. The total charge of $77.6 million resulted primarily from changes in the economics of the Specialty Infusion business unit, including reimbursement changes and resulting decline in gross margin. The Company conducted an additional analysis as of December 31, 2005 and, based on those results, no further impairment was identified. The fair value of the Specialty Infusion business unit was estimated by performing a discounted cash flow analysis for the reporting unit. See Note 6 of Notes to Consolidated Financial Statements.

Interest (Expense) Income. Net interest expense in 2005 was $25.5 million compared to $15.7 million in 2004. The increase of $9.7 million was primarily due to the Company s increased debt used to fund the CCS acquisition in April of 2004 (see Notes 4 and 11 of Notes to Consolidated Financial Statements).

Other (Income) Expense. Other income of $0.7 million and $0 in 2005 and 2004, respectively, and other expense of $0 and $1.1 million in 2005 and 2004, respectively, primarily represented the fair value adjustments of the Company s interest rate swap agreement for those periods. The Company terminated the interest rate swap agreement in June of 2005 (see Note 12 of Notes to Consolidated Financial Statements).

Income tax benefit. The Company recorded an income tax benefit of approximately $3.4 million in 2005 compared to a benefit of $3.9 million in 2004. The tax benefit in 2005 resulted primarily from the Company reversing certain tax reserve items, offset by the recording of a full valuation allowance of $1.4 million against its deferred tax assets.

Net Loss. Loss from continuing operations in 2005 was $99.8 million, or ($7.67) per share, compared to a loss from continuing operations of $140.8 million, or ($10.89) per share in 2004. The loss from continuing operations for 2005 was attributed to the goodwill and intangible asset impairment charges, the increased interest expense related to the Company s Senior Notes, the decreased gross margins for Specialty Infusion and the charges taken primarily related to the Company s corporate office relocation and financial advisory fees.

The Company also recorded loss from discontinued operations of $1.8 million, or $0.14 per share compared to a loss from discontinued operations of $0.6 million, or ($0.04) per share. As a result, the Company had a total net loss in 2005 of $101.6 million, or ($7.81) per share compared to a net loss of $141.4 million, or ($10.93) per share, in 2004.

Fiscal Year 2004 vs. Fiscal Year 2003

Revenues. The Company s revenues increased $61.5 million, or 38%, to $225.0 million for the fiscal year ended December 31, 2004 compared to $163.5 million for the fiscal year ended December 31, 2003. The increase in revenues was the result of the 2004 acquisition of CCS, offset by a reduction in hemophilia revenue related to the reduced reimbursement from California state programs and a reduction in service revenues in the Wound Care Management business unit.

Product revenues, attributed entirely to the Specialty Infusion business unit, increased $63.5 million, or 47%, to $198.1 million in 2004 from $134.6 million in 2003. The increase in product revenues was primarily attributable to the 2004 acquisition of CCS**,** offset by a reduction in hemophilia revenue related to the reduced reimbursement from California state programs and a reduction in IVIG sales. Product revenues for the years ended December 31 included the following:

	2004		2003	
	In millions	% of Specialty Infusion Revenues	In millions	% of Specialty Infusion Revenues
Hemophilia	$ 111.4	56%	$ 115.3	86%
Other branch pharmacy revenue(1)	86.7	44%	19.3	14%
Total Specialty Infusion revenues	$ 198.1	100%	$ 134.6	100%

(1) Includes product, service and per diem revenues for products such as, among others, antibiotics, IVIG, TPN, Remicaid® and chemotherapy.

Service revenues, attributed entirely to the Wound Care Management business unit, decreased $2.0 million, or 7%, to $26.9 million in 2004 from $28.9 million in 2003. The decrease in service revenues was primarily attributable to contract terminations, contract renegotiations resulting in lower average revenues per program and the conversion over the last two years of four under arrangement programs to management service programs where revenues are lower. As of the fiscal year ended 2004, the Company signed 13 new Wound Care Management contracts and 6 contracts were terminated. The improvement in the total number of contracts signed in 2004 versus contracts terminated was the result of a more favorable climate for outsourcing within the hospital market as well as improved financial stability of hospitals generally. Program terminations

by client hospitals have been effected for such reasons as reduced reimbursement, financial restructuring, layoffs, bankruptcies, hospital closings or a hospital s decision to maintain a wound care center without external management. The continued termination, non-renewal or renegotiations of a material number of management contracts or the inability to sign new contracts could result in a continued decline in the Company s Wound Care Management business unit revenue. The Wound Care Management business unit has a number of initiatives to counter the decline in revenue, although there can be no assurance that the initiatives will be successful. These initiatives include new product offerings such as inpatient wound care programs at acute care hospitals focusing on pressure sores, and wound outreach programs whereby nurse practitioners or physicians from affiliated Wound Care Centers provide related services to long-term care facilities in surrounding areas. All of these programs are currently being offered to hospitals.

Cost of Product Sales. Cost of product sales, attributed entirely to the Specialty Infusion business unit, increased $67.6 million, or 76%, to $156.9 million in 2004 compared to $89.2 million in 2003. The increase in cost of product sales was primarily attributable to the 2004 acquisition of CCS. As a percentage of product revenues, cost of product sales in 2004 was 79% compared to 66% in 2003. The increased percentage for 2004 was primarily attributable to the acquisition of CCS which resulted in the reduction of the percentage of the Company s revenues derived from hemophilia products, which have a lower product cost as a percentage of revenue, as well as the reduction in hemophilia revenue related to the reduced reimbursement from California state programs.

Cost of Services. Cost of services, attributed entirely to the Wound Care Management business unit, decreased $1.1 million, or 9%, to $12.1 million in 2004 from $13.2 million in 2003. The decrease in cost of services for 2004 was primarily attributed to the conversion over the last two years of four under arrangement programs to management service programs where expenses are lower. As a percentage of service revenues, cost of services in 2004 was 45% compared to 46% in 2003.

Gross Margin. Gross margin decreased $5.0 million, or 8%, to $56.1 million in 2004 from $61.0 million in 2003. Specialty Infusion s gross margin declined to $41.2 million in 2004 from $45.4 million in 2003, a decrease of $4.2 million, or 9%. As a percentage of its revenues, Specialty Infusion s gross margin was 21% in 2004 as compared to 34% in 2003. The decreases in gross margin dollars and percentage were attributed to lower average revenue per unit for hemophilia as a result of changes in reimbursement rates, lower average revenue per unit for IVIG at pharmacies operating before the CCS acquisition due to a higher mix of managed care business, and a higher cost of service. These decreases were partially offset by the inclusion of the gross margin from the CCS acquisition. Wound Care Management s gross margin slightly decreased to $14.8 million in 2004 from $15.7 million in 2003, or 5%. As a percentage of its revenues, Wound Care Management s gross margin was 55% in 2004 compared to 54% in 2003. The increase was attributed to the conversion over the past two years of four under arrangement contract programs to management services contracts where gross margins are typically higher.

Selling, General and Administrative. Selling, general and administrative expenses increased by $9.0 million, or 22%, to $50.0 million in 2004 compared to $41.0 million in 2003 and consisted of $17.8 million related to the Specialty Infusion business, $4.0 million related to the Wound Care Management business, $18.3 million related to corporate services and $9.9 million in charges. The total 2004 charges of $9.9 million included the following:

Charge		In Millions
Critical Care Systems integration	$	6.8
Litigation expense		1.8
Corporate reorganization		1.3
Total charges	$	9.9

The increase in selling, general and administrative expenses of $9.0 million was due to the charges of $9.9 million in 2004 compared to $6.7 million in charges in 2003 and the 2004 acquisition of CCS which accounted for increases of approximately $3.7 million in Specialty Infusion expenses and $2.8 million due to growth in corporate departments in support of the CCS, offset by a decrease of approximately $0.7 million in Wound Care Management expenses. As a percentage of total revenues, selling, general and administrative expenses were 22% for 2004

compared to 25% for 2003.

Goodwill Impairment. During the fourth quarter of 2004, the Company conducted its impairment test related to the carrying values of goodwill and other intangible assets, attributed entirely to the Specialty Infusion business unit, in accordance with SFAS No. 142, Goodwill and Other Intangible Assets and SFAS No. 144, Accounting for the Impairment or Disposal of Long-Lived Assets, respectively. Based on the results of this evaluation, the Company recorded non-cash impairment charges of $133.9 million in goodwill and $68 thousand in other intangible assets related to the Specialty Infusion business unit. The total charge of $134.0 resulted primarily from changes in the economics of the Specialty Infusion business unit, including the changes in reimbursement methodology that occurred in 2004.

Interest (Expense) Income. Net interest expense in 2004 was $15.7 million compared to $2.3 million in 2003. The increase of $13.4 million was due to the Company s increased debt used to fund the CCS acquisition in April of 2004 (see Notes 4 and 11 of Notes to Consolidated Financial Statements).

Other Expense. Other expense in 2004 was $1.1 million compared to $0 in 2003 and represents the fair value adjustments of the Company s interest rate swap agreement as of December 31, 2004 (see Note 12 of Notes to Consolidated Financial Statements).

Income tax (benefit) provision. The Company recorded an income tax benefit of $3.9 million in 2004 compared to an expense of $7.9 million in 2003. The benefit in 2004 is primarily related to the net pre-tax loss adjusted for non-deductible items such as goodwill impairment.

Net (Loss) Income. Loss from continuing operations in 2004 was $140.8 million, or ($10.89) per share, compared to income from continuing operations of $12.2 million, or $0.89 per diluted share in 2003 (calculated under the as if converted method as described in Note 18 of Notes to Consolidated Financial Statements). The loss from continuing operations for 2004 was attributable to the increase in charges incurred in 2004, increased interest expense related to the Company s Senior Notes, the goodwill impairment charge and the reductions in hemophilia revenue related to the reduced reimbursement from California state programs. The Company also recorded a loss from discontinued operations of $0.6 million or ($0.04) per share, compared to income from discontinued operations of $0.9 million, or $0.07 per diluted share in 2003 (see Note 5 of Notes to Consolidated Financial Statements). As a result, the Company had a total net loss in 2004 of $141.4 million, or ($10.93) per share compared to net income of $13.1 million, or $0.96 per diluted share, in 2003.

LIQUIDITY AND CAPITAL RESOURCES

Working capital deficit was $156.9 million at December 31, 2005 compared to working capital of $50.8 million at December 31, 2004. The decrease in working capital is the result of the Company classifying its debt and other obligation as current (see Notes 2 and 11 of Notes to Consolidated Financial Statements). Total cash and cash equivalents at December 31, 2005 was $1.1 million. The ratio of current assets to current liabilities was 0.39 to 1 at December 31, 2005 and 1.8 to 1 at December 31, 2004.

Cash flows provided by continuing operating activities for 2005 totaled $3.8 million, primarily attributable to the net loss from continuing operations of $99.8 for the year, a $1.1 million change in the fair value of the interest rate swap and a decrease in accounts payable and accrued expenses of $4.0 million, offset by depreciation and amortization of $5.9 million, bad debt provision of $8.4 million, the goodwill and intangible asset impairment charges of $77.6 million and decreases of approximately $0.5 million, $5.2 million and $6.3 million in accounts receivable, inventories and prepaids and other, respectively.

Cash flows provided by continuing investing activities totaled $0.1 million, attributable to $5.9 million in fixed asset purchases, net of $1.6 million in disposals, offset by proceeds of $4.4 million related to the Prescription City Settlement (see Note 4 to Consolidated Financial Statements).

Cash flows used in continuing financing activities totaled $0.6 million, attributable to $1.6 million in borrowings against credit facilities, net of deferred financing costs and $1.5 million in proceeds from repayments of notes receivable from stockholders, offset by $3.7 million in

repayments of notes payable.

At December 31, 2005, the Company experienced a net decrease in accounts receivable of $7.1 million primarily attributable to approximately $4.2 million of additional reserves the Company recorded in the fourth quarter of 2005 and a reduction in days sales outstanding (DSO). DSO was 87 days at December 31, 2005, as compared to 88 days at December 31, 2004. At December 31, 2005, DSO for the Specialty Infusion business unit was 91 days and for the Wound Care Management business unit, DSO was 56 days, compared to 89 days and 73 days, respectively, at December 31, 2004.

As of December 31, 2005, the Company s debt and other obligation of $213.2 million included $185.0 million in Senior Notes, $26.3 million in borrowed funds from the Company s commercial lender, $0.4 million representing the DOJ obligation and $1.5 million representing the convertible note used in connection with the purchase of Apex in February 2002. On October 26, 2005, the Company commenced litigation against former stockholders of Apex alleging, among other things, that stockholders of Apex made material misrepresentations in connection with their sale of Apex stock to Curative in 2002. Prior to commencement of the action, Curative notified the representative of the former stockholders indicating that it would not be making the installment payment due on December 31, 2005 or any further payments pending resolution of this dispute (see Item 3, Legal Proceedings). The Company s debt

and other obligation were classified as current liabilities under generally accepted accounting principles as of December 31, 2005 (see Notes 2 and 11 of Notes to Consolidated Financial Statements).

The total of the Company s debt and other obligation and long-term liabilities decreased $4.2 million to $213.2 million compared to $217.5 million at December 31, 2004. The decrease was primarily due to a decrease in the DOJ obligation resulting from payments made in 2005, the release of the obligation to pay a $1.0 million promissory note entered into in connection with the asset purchase of Prescription City (see Note 11 of Notes to Consolidated Financial Statements) and the repayment of the $3.0 million note payable in connection with the purchase of Home Care of New York, Inc.

The Company s current liquidity needs include those related to working capital needs for the servicing of its debt, approximately $19.9 million in interest expense, paid semi-annually, related principally to the Company s outstanding Senior Notes, a $0.4 million obligation payable to the DOJ related to the settlement of its litigation previously disclosed and the expansion of the Company s branch network of full-service pharmacies, including capital expenditure requirements of approximately $3.0 million.

On May 2, 2005, the Company made the first 2005 semi-annual interest payment of approximately $9.75 million on the Senior Notes, and on October 23, 2005, the Company paid the $3.0 million convertible note related to the purchase of Home Care. The Company made these payments by drawing against its revolving credit facility. The Company did not, however, pay the November 1, 2005 coupon due on the Senior Notes and instead elected to use the 30-day grace period under the Note indenture to continue to negotiate with the Ad Hoc Committee of the bondholders and their financial advisor regarding a restructuring of the Senior Notes.

As previously disclosed, the Company hired a financial advisor to assess the financial alternatives available to the Company given its significant debt and continuing losses. In addition, the Ad Hoc Committee comprised of the holders of approximately 80% of the Company s Senior Notes hired a financial advisor as well.

In connection with the Existing Credit Facility, on December 1, 2005, the Company entered into a Forbearance Agreement with GECC. The Forbearance Agreement provides that, subject to certain conditions, GECC, together with the other lenders under the Existing Credit Facility, which is governed by the Credit Agreement, will forbear from exercising remedies on account of the cross-default under the Credit Agreement arising from the Company s failure to pay interest on the Senior Notes. Subject to certain termination events, including additional events of default under the Credit Agreement, the Forbearance Agreement will expire on June 10, 2006. Under the terms of the Forbearance Agreement, Curative may continue to draw-down under the Credit Agreement as if such existing events of default had not occurred. Upon termination of the Forbearance Agreement, all obligations under the Credit Agreement, together with interest, will be immediately due and payable and the lenders may exercise any rights or remedies thereunder.

The Forbearance Agreement provides that interest on outstanding amounts on the revolver facility will accrue at the default rate under the agreement, but paid at the rate in the agreement as if no event of default had occurred. The difference between interest accrued and interest paid, the PIK spread, becomes due and payable at the end of the forbearance period, provided however that GECC will waive such additional interest due as long as: 1) a terminating event under the facility does not occur, 2) the Company accepts GECC s proposal for a DIP Credit facility and 3) GECC provides the Exit Facility (see Note 1 of Notes to Consolidated Financial Statements). In addition, the Forbearance Agreement waives payment of an early termination fee that became due and payable of $1.2 million, subject to the same conditions as the PIK interest. The Company recorded the $1.2 million termination penalty and PIK interest in the accompanying financial statements. Further, the Company was not in compliance with the financial covenants of total leverage, senior secured leverage and fix charges coverage ratios under its revolving credit facility at December 31, 2005, and the Company and GECC executed a waiver agreement related to these covenants. As of April 5, 2006, our obligations under our Existing Credit Facility with GECC have been paid in full in connection with the interim order of the Bankruptcy Court authorizing the DIP Financing described below. The DIP Financing remains subject to approval by the Bankruptcy Court on a final basis.

If the Bankruptcy Court does not enter a final order approving the DIP Financing, the Existing Credit Facility will be reinstated.

On December 2, 2005, the Company reached an agreement with the Ad Hoc Committee on the general terms of a financial restructuring and entered into a Plan Support Agreement. The financial restructuring, as contemplated by the Plan Support Agreement and the Plan, is designed to (a) de-leverage the Company s balance sheet, (b) provide substantial liquidity to conduct business operations, (c) ensure that business operations are unaffected by the Chapter 11 Cases and that the Company is able to retain existing management and employees and (d) provide the greatest return to creditors. Under the Plan Support Agreement, the Senior Noteholders party thereto agreed to forbear from exercising remedies with respect to any defaults and events of defaults arising, or that may arise, under the Senior

Notes, and agreed further to take all commercially reasonable actions to oppose and object to, and not to support, any person s taking action to exercise remedies with respect to the Senior Notes. The Plan Support Agreement will terminate on July 31, 2006, or upon the earlier failure to satisfy certain milestones with respect to the Plan.

On March 27, 2006, Curative and each of its direct and indirect subsidiaries filed voluntary petitions under chapter 11 of the Bankruptcy Code in the Bankruptcy Court. The Company filed the Chapter 11 Cases to implement and effect the Plan. Prior to commencement of the Chapter 11 Cases, the Company solicited votes to accept or reject the Plan from the holders of the Senior Notes issued by Curative and the holders of known general unsecured claims against the Company as of February 6, 2006. Prior to the commencement of the Chapter 11 Cases, the Company received the requisite votes for the Plan to be confirmable under Section 1129 of the Bankruptcy Code.

The Plan was filed with the Bankruptcy Court on March 27, 2006. The Plan will, if confirmed and consummated, result in the cancellation and discharge of all claims relating to the Senior Notes. Each Senior Noteholder will receive a cash payment of approximately 54.9% of its respective claim related to the Senior Notes, unless a Senior Noteholder was qualified to elect and did elect to receive its pro rata share of certain cash consideration provided in the Plan and the New Curative Common Stock. Holders of existing shares of Old Curative Common Stock and options will not receive any distributions under the Plan and all shares of Old Curative Common Stock and options will be extinguished.

The Bankruptcy Court entered an interim order authorizing the Company to enter into a $45.0 million debtor-in-possession credit facility that is secured by all or substantially all of the Company s assets and a pledge of the equity interests of each of its subsidiaries, or DIP Financing). The proceeds of the DIP Financing were used to pay, in full, all amounts outstanding under the Existing Credit Facility as of April 5, 2006 and also will be used for working capital and other general corporate purposes during the Chapter 11 Cases.

The DIP Financing provides for a secured revolving credit facility of up to $45.0 million, of which the Company can use up to $7.5 million as a letter of credit sub facility and up to $5.0 million as a swingline sub facility (i.e., a short-term loan advance facility). The Company used the facility immediately to pay all of its outstanding borrowings under the previous facility.

The Company will pay all accrued interest on outstanding LIBOR loans on the last day of the applicable LIBOR period, provided in the case of any LIBOR period greater than three months in duration, interest shall be payable at three month intervals and on the last day of such LIBOR period. All accrued interest on outstanding revolving credit LIBOR loan advances will bear interest at an annual rate equal to the LIBOR rate plus an additional amount based on the Company s senior leverage ratio, which additional amounts may range from 3% to 3.5%. For outstanding base rate loans, the Company will pay all accrued interest on the first business day of each calendar quarter. All accrued interest on outstanding revolving credit base rate loans bears interest at an annual rate equal to the base rate plus an additional amount based on the Company s senior leverage ratio, which additional amounts may range from 1.75% to 2.25% for the revolving credit base rate loans.

In the DIP Financing Credit Agreement, the Company has made certain representations and warranties to GECC and is subject to certain reporting requirements and financial and other covenants. The credit facility restricts the Company s ability to incur or to permit any of its properties or assets to be encumbered by liens. The credit facility also restricts the Company s ability to make certain types of payments relating to its capital stock, including the declaration or payment of dividends. Consolidations, mergers, sales of assets and the creation of additional subsidiaries are also restricted, as is the Company s ability to purchase assets and to make investments. The covenants also restrict transactions with the Company s affiliates and require the Company to maintain certain levels with respect to its total leverage ratio, senior leverage ratio and fixed charge coverage ratio. The DIP facility provided for conditions to close which included covenants related to levels of the Company s fixed charges coverage ratio, senior secured leverage ratio and total leverage ratio. The Company was in compliance with these as well as other requirements as of the close date.

The Company s longer term cash requirements include working capital for the expansion of its Specialty Infusion business branch pharmacy network and servicing of the Company s substantial debt. Other cash requirements are anticipated for capital expenditures in the normal course of business, including the acquisition of software, computers and equipment related to the Company s management information systems.

COMMITMENTS AND CONTRACTUAL OBLIGATIONS

At December 31, 2005, the Company had an approximate $0.4 million obligation, payable in February 2006, to the DOJ related to the settlement of its litigation previously disclosed, as well as bank debt and convertible and promissory notes totaling $212.9 million payable over various periods through 2011 that were used in the Specialty Infusion acquisitions (see Note 4 of Notes to Consolidated Financial Statements). In addition, the Company has contractual obligations under various operating leases.

The following table details total future payments under these obligations at December 31, 2005 (in thousands):

	Total	Less than 1 year	1 3 years	3 5 years	More than 5 years
Senior subordinated notes(1)	$ 185,000	$ 185,000	$	$	$
Revolving loan facility(1)	26,346	26,346			
DOJ obligation	375	375			
Convertible note payable(2)	1,524	1,524			
Operating leases	16,338	4,201	7,059	3,898	1,180
Total	$ 229,583	$ 217,446	$ 7,059	$ 3,898	$ 1,180

(1) Due to the Company s current financial condition, all of the Company s outstanding debt has been classified as current in the accompanying financial statements (see Notes 2 and 11 of Notes to Consolidated Financial Statements).

(2) Currently in dispute (see Note 21 of Notes to Consolidated Financial Statements).

The effects of inflation and changing prices are considered immaterial.

RECENTLY ISSUED ACCOUNTING STANDARD

In December 2004, the Financial Accounting Standards Board (FASB) issued SFAS No. 123 (revised 2004), Share-Based Payment, (SFAS No. 123(R)) which eliminated the alternative of accounting for share-based compensation transactions under the intrinsic value method of APB No. 25. Instead, SFAS No. 123(R) requires companies to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The grant-date fair value of employee share options and similar instruments will be estimated using option-pricing models adjusted for the unique characteristics of those instruments. The Company adopted SFAS No. 123(R) on January 1, 2006.

Given the Company s filing for Chapter 11 reorganization as described above, the cancellation of the Company s stock as well as existing options and the expected issuance of new options at prices to be determined, the impact of adoption of SFAS No. 123(R) on future net income cannot be predicted at this time. SFAS No. 123(R) also requires the benefits of tax deductions in excess of recognized compensation cost to be reported as a financing activity, rather than as an operating activity as currently presented. This requirement will reduce net operating cash flows and increase net financing cash flows in periods after adoption. While future tax deduction amounts cannot be determined at this time, the amount of tax benefit from stock option exercises recorded in operating cash flows recognized in prior periods included no benefit in 2005 or 2004 and $1.5 million in 2003.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The Company currently does not have market risk sensitive instruments entered into for trading purposes and does not have operations subject to risks of material foreign currency fluctuations. The Company does not enter into derivative instruments other than for cash flow hedging purposes and does not speculate using derivative instruments.

For non-trading purposes, the Company is subject to interest rate risk under its Existing Credit Facility. In conjunction with the acquisition of CCS on April 23, 2004, the Company restructured its previous credit facility with GECC to provide for a $40.0 million senior secured revolving credit facility. Loans under this Existing Credit Facility may, at the Company s option, be obtained as Base Rate loans, LIBOR loans or any combination thereof. This credit facility was to terminate on April 23, 2009.

In connection with the Existing Credit Facility, on December 1, 2005, the Company entered into a Forbearance Agreement with GECC. The Forbearance Agreement provides that, subject to certain conditions, GECC, together with the other lenders under the Existing Credit Facility, which is governed by the Credit Agreement, will forbear from exercising remedies on account of the cross-default under the Credit Agreement arising from the Company s failure to pay interest on the Senior Notes. Subject to certain termination events, including additional events of default under the Credit Agreement, the Forbearance Agreement will expire on June 10, 2006. Under the terms of the Forbearance Agreement, Curative may continue to draw-down under the Credit Agreement as if such existing events of default had not occurred. Upon termination of the Forbearance Agreement, all obligations under the Credit Agreement, together with interest, will be immediately due and payable and the lenders may exercise any rights or remedies thereunder.

The Forbearance Agreement provides that interest on outstanding amounts on the revolver facility will accrue at the default rate under the agreement, but paid at the rate in the agreement as if no event of default had occurred. The difference between interest accrued and interest paid, the PIK spread, becomes due and payable at the end of the forbearance period, provided however that GECC will waive such additional interest due as long as: 1) a terminating event under the facility does not occur, 2) the Company accepts GECC s proposal for a DIP Credit facility and 3) GECC provides the Exit Facility (see Note 1 of Notes to Consolidated Financial Statements). In addition, the Forbearance Agreement waives payment of an early termination fee that became due and payable of $1.2 million, subject to the same conditions as the PIK interest. The Company recorded the $1.2 million termination penalty and PIK interest in the accompanying financial statements. As of April 5, 2006, our obligations under our Existing Credit Facility with GECC have been paid in full in connection with the interim order of the Bankruptcy Court authorizing the DIP Financing. The DIP Financing remains subject to approval by the Bankruptcy Court on a final basis. If the Bankruptcy Court does not enter a final order approving the DIP Financing, the Existing Credit Facility will be reinstated.

The table below provides information about the Company s financial instruments, in accordance with stated terms of related agreements, that are sensitive to changes in interest rates. For debt obligations, the table presents principal amounts outstanding and related weighted average interest rates. As a result of the Company s financial condition and its filing of a Plan of Reorganization under Chapter 11, all of the Company s outstanding indebtedness is classified as current.

The following table provides information about the Company s financial instruments at December 31 (dollars in millions):

	December 31, 2005		Outstanding Balances December 31,					
	Balance	Fair Value	2006	2007	2008	2009	2010	There-after
Liability:								
Long-term debt (Senior Notes)	$	$	$	$	$	$	$	$
Fixed rate ($US)(1)	185.0	118.4	185.0					
Average interest rate(1)	10.75%	22.72%	10.75%					
Long-term debt (Revolver)	$	$	$	$	$	$	$	$
Variable rate ($US)(2)	26.3	26.3	26.3					
Average interest rate(2)	7.9%	7.9%	8.63%					
Convertible note used in purchase of Apex	$	$	$	$	$	$	$	$
Average interest rate(3)	1.5 4.4%	1.5 4.4%	1.5 4.4%					
Department of Justice obligation	$	$	$ 0.4	$	$	$	$	$
Average interest rate(4)	0.4 6.0%	0.4 6.0%	6.0%					

(1) The Senior Notes mature in May of 2011 and bear interest at a fixed rate of 10.75%.

(2) The average interest rates are based on the LIBOR forward yield curves at December 31, 2005 plus the applicable 3.5% premium. The senior secured revolving credit facility terminates on April 23, 2009. The LIBOR interest rate in effect at December 31, 2005 was the 30-day LIBOR rate of 4.4% plus 3.5%. On a monthly basis, a Base Rate of prime plus 2.25% is applied to the difference between the LIBOR period loan and the actual outstanding balance of the revolving facility. As of December 31, 2005, the prime rate in effect was 7.0%. In addition to the LIBOR and Base Rate interest rate, there is a monthly unused line fee of between 0.5% and 0.75% of the unused balance on the facility.

(3) Average interest rates are contractual amounts. The Company is disputing this obligation (see Part I, Item 3, Legal Proceedings).

(4) Average interest rates are contractual amounts.

ITEM 8. CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The information required by this item is incorporated herein by reference to the Consolidated Financial Statements listed in Item 15(a) of Part IV of this Report.

This table should be read together with the accompanying Consolidated Financial Statements and Notes. The period-to-period comparability of the Company s selected consolidated financial data is affected by its acquisition activity. See Note 4 of Notes to Consolidated Financial Statements.

The following table sets forth the unaudited financial results of the Company for the eight quarters ended December 31, 2005 (in thousands, except per share data)(1):

	Total Revenues(1)	Gross Profit(1)	Net Loss	Income Per Common Share, Basic(3)	Net Loss Per Common Share, Diluted(2)(3)
Quarter Ended					
2005					
December 31	$ 68,715	$ 14,803	$ (12,528)	$ (0.96)	$ (0.96)
September 30	67,135	14,020	(80,926)	(6.22)	(6.22)
June 30	65,879	13,313	(4,774)	(0.37)	(0.37)
March 31	59,330	12,732	(3,364)	(0.26)	(0.26)
2004					
December 31	$ 62,018	$ 12,638	$ (139,340)	$ (10.77)	$ (10.77)
September 30	64,398	15,115	(2,066)	(0.16)	(0.16)
June 30	59,190	15,117	(3,132)	(0.24)	(0.24)
March 31	39,374	13,180	3,133	0.24	0.23

(1) Excludes amounts from discontinued operations. See Note 5 of Notes to Consolidated Financial Statements.

(2) See Note 18 of Notes to Consolidated Financial Statements for net (loss) income per share calculation.

(3) Weighted average shares used in the above calculations have been corrected for 2004. Such correction resulted in an increase in net loss per share of $.01 for the fourth quarter of 2004

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

Under the supervision and with the participation of the Company s management, including its Chief Executive Officer (CEO) and Chief Financial Officer (CFO), the Company evaluated the effectiveness of the design and operation of the Company s disclosure controls and procedures (as defined in Rule 13a-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act)) as of the end of the period covered by this report on Form 10-K. Based on this evaluation, the Company noted a deficiency in the effectiveness of the Company s financial statement close process in three non-routine, judgmental areas relating to the allowance for doubtful accounts, certain accrued liabilities relating to the Company s revolving credit facility and certain income tax accounts. As a result of this deficiency, audit adjustments increasing the Company s net loss in the aggregate amount of $6.2 million were recorded by the Company. Accordingly, the CEO and CFO concluded that, due to the material weakness in the Company s internal controls, the Company s disclosure controls and procedures were not effective as of December 31, 2005.

Any system of controls, however well designed and operated, can provide only reasonable, and not absolute, assurance that the objectives of the system will be met. In addition, the design of any control system is based, in part, upon certain assumptions about the likelihood of future events. Because of these and other inherent limitations of control systems, there is only reasonable assurance that the Company s controls will succeed in achieving their goals under all potential future conditions.

Changes in Internal Controls

Except as noted above, there were no changes in the Company s internal control over financial reporting that occurred during the fourth quarter of 2005 that have materially affected, or are reasonably likely to materially affect, the Company s internal control over financial reporting.

Remediation of Material Weakness in Internal Control over Financial Reporting

In order to address the material weakness noted above, the Company has revised its financial statement closing procedures to provide for broader review and discussion of such non-routine judgments in the future which will involve, as appropriate, legal counsel, additional internal financial staff, and outside financial advisors. Based on these changes in the financial statement closing process, management of the Company believes that the Company s disclosure controls and procedures are effective as of the date of filing of this report on Form 10-K.

ITEM 9B. OTHER INFORMATION

None.

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PART III

The information required by Part III of this Form 10-K is omitted from this Report in that the Registrant will file a definitive proxy statement pursuant to Regulation 14(a) for its 2006 Annual Meeting of Shareholders (the Proxy Statement) not later than 120 days after the end of the fiscal year covered by this Report, and certain information included therein is incorporated herein by reference.

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF THE REGISTRANT

The information required by this Item is incorporated by reference to the sections Election of Directors, Executive Officers and Section 16(a) Beneficial Ownership Reporting Compliance of the Company s Proxy Statement. The Company has adopted a Code of Ethics that applies to the Company s Chief Executive Officer and senior financial officers. The text of such Code of Ethics has been posted on the Company s website at www.curative.com. Any amendment to, or waiver from, a provision of such Code of Ethics shall be posted on the Company s website at www.curative.com. In addition, the Company has adopted a Code of Business Practices as part of its compliance program, and a copy of such Code of Business Practices is available upon written request to the Company.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item is incorporated by reference to the sections Executive Compensation and Election of Directors Compensation of Directors of the Company s Proxy Statement.

ITEM 12 SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT

The information required by this Item is incorporated by reference to the sections Stock Ownership of Certain Beneficial Owners and Management and Equity Compensation Plan Information of the Company s Proxy Statement.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS

The information required by this Item is incorporated by reference to the section Certain Transactions of the Company s Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is incorporated by reference to the section Ratification of Appointment of Independent Auditors of the Company s Proxy Statement.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) The following documents are included with the filing of this report:

1. Index to Financial Statements

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets at December 31, 2005 and 2004

Consolidated Statements of Operations for the years ended December 31, 2005, 2004 and 2003

Consolidated Statements of Stockholders Equity for the years ended December 31, 2005, 2004 and 2003

Consolidated Statements of Cash Flows for the years ended December 31, 2005, 2004 and 2003

Notes to Consolidated Financial Statements

2. Financial Statement Schedules

Schedule II - Consolidated Schedule - Valuation and Qualifying Accounts

All other schedules are omitted because they are not applicable, or not required, or because the required information is included in the consolidated financial statements or notes thereto.

(b) Exhibits

The list of exhibits, entitled Exhibits, immediately following the financial statement schedules accompanying this report is incorporated herein by reference.

SIGNATURES

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

CURATIVE HEALTH SERVICES, INC.

By: /s/ Paul F. McConnell
Paul F. McConnell
Chief Executive Officer
(Principal Executive Officer)

Date: April 10, 2006

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints Paul F. McConnell, John C. Prior and Thomas Axmacher, jointly and severally, his attorneys-in-fact, each with the power of substitution, for him in any and all capacities, to sign any amendments to this Report on Form 10-K, and to file the same, with exhibits thereto and other documents in connection therewith, with the Securities and Exchange Commission, hereby ratifying and confirming all that each of said attorneys-in-fact, or his substitute or substitutes, may do or cause to be done by virtue hereof.

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

Signature	Title	Date
/s/ Paul F. McConnell Paul F. McConnell	Chief Executive Officer (Principal Executive Officer, Director)	April 10, 2006
/s/ Thomas Axmacher Thomas Axmacher	Chief Financial Officer (Principal Financial and Accounting Officer)	April 10, 2006
/s/ John C. Prior John C. Prior	Chief Operating Officer Director	April 10, 2006
/s/ Paul S. Auerbach, MD Paul S. Auerbach, MD	Director	April 10, 2006
/s/ Daniel E. Berce Daniel E. Berce	Director	April 10, 2006
/s/ Lawrence English Lawrence English	Director	April 10, 2006

/s/ Timothy I. Maudlin Timothy I. Maudlin		Chairman of the Board	April 10, 2006
/s/ Gerard Moufflet Gerard Moufflet		Director	April 10, 2006

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Curative Health Services, Inc.

We have audited the accompanying consolidated balance sheets of Curative Health Services, Inc. and subsidiaries as of December 31, 2005 and 2004, and the related consolidated statements of operations, stockholders (deficit) equity, and cash flows for each of the three years in the period ended December 31, 2005. Our audits also included the financial statement schedule listed in the Index at Item 15(a). These financial statements and schedule are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company s 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, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Curative Health Services, Inc. and subsidiaries at December 31, 2005 and 2004, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2005, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

The accompanying financial statements have been prepared assuming that Curative Health Services, Inc. and subsidiaries will continue as a going concern. As more fully described in Note 1, the Company defaulted on its outstanding debt obligations during 2005 and, subsequent to year end, has filed voluntary petitions under chapter 11 of the United States Bankruptcy Code. These conditions raise substantial doubt about the Company s ability to continue as a going concern. Management s plans in regard to these matters are also described in Notes 1 and 2. The financial statements do not include any adjustments to reflect the possible future effects on the recoverability and classification of assets or the amounts and classification of liabilities that may result from the outcome of this uncertainty.

/s/ Ernst & Young LLP

Manchester, New Hampshire
March 27, 2006, except for Notes 1, 2 and 11,
as to which the date is April 5, 2006

CURATIVE HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(Dollars in thousands)

	December 31,	
	2005	**2004**
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,099	$ 415
Accounts receivable (less allowance of $7,416 and $3,560 at December 31, 2005 and 2004, respectively)	66,487	73,544
Inventories	10,495	15,381
Prepaids and other current assets	3,529	5,650
Deferred financing fees	9,913	
Federal income tax refund receivable	756	3,431
Deferred income taxes	5,860	3,977
Current assets of discontinued operations	2,278	12,010
Total current assets	100,417	114,408
Property and equipment, net	11,934	10,906
Intangibles subject to amortization, net	18,548	20,383
Intangibles not subject to amortization (trade names)	1,440	1,446
Goodwill	36,387	119,559
Other assets	367	12,979
Non-current assets of discontinued operations	195	4,103
Total assets	$ 169,288	$ 283,784
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY		
Current liabilities:		
Accounts payable	$ 13,133	$ 23,774
Accrued expenses and other current liabilities	29,879	21,026
Debt in default and other obligation	213,245	5,496
Current liabilities of discontinued operations	1,035	13,324
Total current liabilities	257,292	63,620
Long-term liabilities		210,991
Deferred income taxes	5,860	3,511
Other long-term liabilities	74	1,209
Non-current liabilities of discontinued operations	395	
Total long-term liabilities	6,329	215,711
Commitments and contingencies		
Stockholders (deficit) equity:		
Preferred stock, $.01 par value per share; 10,000,000 shares authorized, none issued		
Preferred stock, Series A Junior Participating, par value $.01 per share, 500,000 shares authorized, none issued		
Common stock, $.01 par value per share; 50,000,000 shares authorized, 13,043,133 shares issued and outstanding (12,951,462 shares in 2004)	129	128
Additional paid in capital	120,293	119,449
Accumulated deficit	(212,879)	(111,287)
Deferred compensation	(1,876)	(2,364)
Notes receivable stockholders		(1,473)
Total stockholders (deficit) equity	(94,333)	4,453
Total liabilities and stockholders (deficit) equity	$ 169,288	$ 283,784

See accompanying notes

CURATIVE HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

(All amounts in thousands, except per share data)

	Years Ended December 31,		
	2005	**2004**	**2003**
Revenues:			
Products	$ 232,169	$ 198,055	$ 134,596
Services	28,890	26,925	28,898
Total revenues	261,059	224,980	163,494
Costs and operating expenses:			
Cost of product sales	193,206	156,854	89,241
Cost of services	12,985	12,076	13,224
Selling, general and administrative	55,702	50,042	40,995
Goodwill and intangible asset impairment	77,608	133,969	
Total costs and operating expenses	339,501	352,941	143,460
(Loss) income from operations	(78,442)	(127,961)	20,034
Interest expense	(25,491)	(15,833)	(2,300)
Interest income	23	107	20
Other expense		(1,081)	
Other income	712		2,327
(Loss) income from continuing operations before income taxes	(103,198)	(144,768)	20,081
Income tax (benefit) provision	(3,415)	(3,949)	7,909
(Loss) income from continuing operations	(99,783)	(140,819)	12,172
Discontinued operations:			
Income (loss) from discontinued operations	(1,254)	(471)	1,490
Loss on sale of discontinued operations	(933)		
Income tax (benefit) provision	(378)	115	587
(Loss) Income from discontinued operations	(1,809)	(586)	903
Net (loss) income	$ (101,592)	$ (141,405)	$ 13,075
Basic net (loss) income per share:			
(Loss) income from continuing operations	$ (7.67)	$ (10.89)	$ 0.97
Income (loss) from discontinued operations	(0.14)	(0.04)	0.07
Net (loss) income	$ (7.81)	$ (10.93)	$ 1.04
Diluted net (loss) income per share:(1)			
(Loss) income from continuing operations	$ (7.67)	$ (10.89)	$ 0.89
Income (loss) from discontinued operations	(0.14)	(0.04)	0.07
Net (loss) income	$ (7.81)	$ (10.93)	$ 0.96
Denominator for basic net (loss) income per share, weighted average common shares	13,002	12,932	12,536
Denominator for diluted net (loss) income per share, weighted average common shares assuming conversions	13,002	12,932	13,816

(1) See Note 18 of Notes to Consolidated Financial Statements for net (loss) income per share calculation.

See accompanying notes

CURATIVE HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY (DEFICIT)

(Dollars in thousands)

	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings (Accumulated Deficit)	Deferred Compensation	Notes Receivable Stockholders	Total Stockholders Equity (Deficit)
Balance, December 31, 2002	12,142,106	$ 121	$ 106,124	$ 17,043		$ (2,387)	$ 120,901
Exercise of options	485,863	4	4,136				4,140
Exercise of rights under convertible notes	300,389	3	4,828				4,831
Tax benefit from stock option exercises			1,517				1,517
Repayment of notes receivable-stockholders						780	780
Shares repurchased and retired	(97,070)	(1)	(1,523)				(1,524)
Net income for 2003				13,075			13,075
Balance, December 31, 2003	12,831,288	127	115,082	30,118		(1,607)	143,720
Exercise of options and other	47,459	1	303				304
Grant of restricted common stock			2,896		(2,896)		
Amortization of deferred stock compensation					532		532
Exercise of rights under convertible notes	72,715		1,168				1,168
Repayment of notes receivable-stockholders						134	134
Net loss for 2004				(141,405)			(141,405)
Balance, December 31, 2004	12,951,462	128	119,449	(111,287)	(2,364)	(1,473)	4,453
Grant/issuance of restricted stock	91,671	1	844		(844)		1
Amortization of deferred stock compensation					1,332		1,332
Repayment of notes receivable-stockholders						1,473	1,473
Net loss for 2005				(101,592)			(101,592)
Balance, December 31, 2005	13,043,133	$ 129	$ 120,293	$ (212,879)	$ (1,876)	$	$ (94,333)

See accompanying notes

CURATIVE HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

(Dollars in thousands)

	2005	2004	2003
OPERATING ACTIVITIES:			
(Loss) income from continuing operations	$ (99,783)	$ (140,819)	$ 12,172
Adjustments to reconcile net (loss) income to net cash provided by (used in) continuing operating activities:			
Depreciation and amortization	5,883	4,925	