APRIA HEALTHCARE GROUP INC
Form 10-Q
May 01, 2013
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended March 31, 2013

or

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

For the transition period from to .

Commission file number 333-168159

APRIA HEALTHCARE GROUP INC.

(Exact name of Registrant as specified in its charter)

Delaware	**33-0488566**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

26220 Enterprise Court

Lake Forest, CA	**92630**
(Address of principal executive offices)	**(Zip Code)**

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

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

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

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

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

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

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

As of April 30, 2013, there were 100 shares of the issuer s common stock, par value $0.01 per share, issued and outstanding.

Table of Contents

APRIA HEALTHCARE GROUP INC.

FORM 10-Q

TABLE OF CONTENTS

		Page No.
	PART I Financial Information	
Item 1.	Financial Statements	4
	Unaudited Condensed Consolidated Balance Sheets as of March 31, 2013 and December 31, 2012	4
	Unaudited Condensed Consolidated Statements of Operations for the three months ended March 31, 2013 and March 31, 2012	5
	Unaudited Condensed Consolidated Statements of Cash Flows for the three months ended March 31, 2013 and March 31, 2012	6
	Notes to Unaudited Condensed Consolidated Financial Statements	7
Item 2.	Management s Discussion and Analysis of Financial Condition and Results of Operations	30
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	53
Item 4.	Controls and Procedures	54
	PART II Other Information	
Item 1.	Legal Proceedings	55
Item 1A.	Risk Factors	55
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	69
Item 3.	Defaults Upon Senior Securities	69
Item 4.	Mine Safety Disclosures	69
Item 5.	Other Information	69
Item 6.	Exhibits	70
SIGNATURES		71

Table of Contents

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

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

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

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

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

As used in this report, unless otherwise noted or the context otherwise requires, references to Company, we, us, and our are to Apria Healthcare Group Inc., a Delaware corporation, and its subsidiaries; references to Apria and the Issuer are to Apria Healthcare Group Inc., exclusive of its subsidiaries; references to Merger Sub are to Sky Merger Sub Corporation, a Delaware corporation; references to Holdings are to Apria Holdings LLC, a Delaware limited liability company, exclusive of its subsidiaries; references to Sky LLC or Buyer are to Sky Acquisition LLC , a Delaware limited liability company, exclusive of its subsidiaries; references to Blackstone and the Sponsor are to Blackstone Capital Partners V L.P.; references to the Investor Group are, collectively, to Blackstone and certain funds affiliated with Blackstone, Dr. Norman C. Payson and certain other members of our management; and references to home medical equipment, durable medical equipment and DME are used synonymously. On October 28, 2008, the Company was acquired by private investment funds affiliated with the Sponsor via a merger of the

Merger Sub with and into Apria (the Merger), with Apria being the surviving corporation following the Merger. As a result of the Merger, the Investment Group beneficially owns all of Apria s issued and outstanding common stock.

Table of Contents

PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

APRIA HEALTHCARE GROUP INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(Unaudited)

	March 31, 2013	December 31, 2012
	(in thousands, except share data)	
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 15,523	$ 27,080
Accounts receivable, less allowance for doubtful accounts of $60,447 and $53,017 at March 31, 2013 and December 31, 2012, respectively	349,877	344,421
Inventories	71,200	68,075
Deferred expenses	3,701	3,798
Prepaid expenses and other current assets	23,190	16,890
TOTAL CURRENT ASSETS	463,491	460,264
PATIENT SERVICE EQUIPMENT, less accumulated depreciation of $186,885 and $185,774 at March 31, 2013 and December 31, 2012, respectively	190,482	186,460
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	74,498	76,823
GOODWILL	258,725	258,725
INTANGIBLE ASSETS, NET	133,595	133,781
DEFERRED DEBT ISSUANCE COSTS, NET	26,373	30,207
OTHER ASSETS	28,172	26,448
TOTAL ASSETS	$ 1,175,336	$ 1,172,708
LIABILITIES AND STOCKHOLDERS DEFICIT		
CURRENT LIABILITIES		
Accounts payable	$ 147,239	$ 157,530
Accrued payroll and related taxes and benefits	70,811	70,547
Deferred income taxes	2,730	986
Other accrued liabilities	101,089	74,464
Deferred revenue	27,246	27,785
Current portion of long-term debt	12,136	25,195
TOTAL CURRENT LIABILITIES	361,251	356,507
LONG-TERM DEBT, net of current portion	1,017,500	1,017,515
DEFERRED INCOME TAXES	67,539	68,907
INCOME TAXES PAYABLE AND OTHER NON-CURRENT LIABILITIES	61,042	61,203
TOTAL LIABILITIES	1,507,332	1,504,132
COMMITMENTS AND CONTINGENCIES		
STOCKHOLDERS DEFICIT		
Common stock, $0.01 par value: 1,000 shares authorized; 100 shares issued at March 31, 2013 and December 31, 2012		
Additional paid-in capital	696,532	695,211
Accumulated deficit	(1,028,528)	(1,026,635)

TOTAL STOCKHOLDERS DEFICIT	(331,996)	(331,424)
	$ 1,175,336	$ 1,172,708

See notes to unaudited condensed consolidated financial statements.

Table of Contents

APRIA HEALTHCARE GROUP INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

(Unaudited)

	Three Months Ended March 31,	
	2013	2012
	(in thousands)	
Net revenues:		
Fee-for-service arrangements	$ 569,520	$ 551,616
Capitation	45,235	44,097
TOTAL NET REVENUES	614,755	595,713
Costs and expenses:		
Cost of net revenues:		
Product and supply costs	220,754	207,412
Patient service equipment depreciation	19,458	20,696
Home respiratory therapy services	5,649	7,289
Nursing services	9,953	11,223
Other	4,408	5,046
TOTAL COST OF NET REVENUES	260,222	251,666
Provision for doubtful accounts	23,135	11,858
Selling, distribution and administrative	299,149	317,422
Amortization of intangible assets	186	661
TOTAL COSTS AND EXPENSES	582,692	581,607
OPERATING INCOME	32,063	14,106
Interest expense	34,212	33,517
Interest income and other	(510)	(702)
LOSS BEFORE TAXES	(1,639)	(18,709)
Income tax benefit	254	898
NET LOSS	$ (1,893)	$ (19,607)

See notes to unaudited condensed consolidated financial statements.

Table of Contents

APRIA HEALTHCARE GROUP INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(Unaudited)

	Three Months Ended March 31,	
	2013	2012 (As Restated See Note 2)
	(in thousands)	
OPERATING ACTIVITIES		
Net loss	$ (1,893)	$ (19,607)
Items included in net loss not requiring cash:		
Provision for doubtful accounts	23,135	11,858
Depreciation	26,361	28,705
Amortization of intangible assets	186	661
Amortization of deferred debt issuance costs	3,834	3,451
Deferred income taxes	375	137
Profit interest compensation	1,321	739
Gain on sale of patient service equipment and other	(6,086)	(5,915)
Changes in operating assets and liabilities, exclusive of effects of acquisitions		
Accounts receivable	(28,592)	(37,125)
Inventories	(3,125)	(6,344)
Prepaid expenses and other assets	(8,026)	(2,575)
Accounts payable	(6,360)	15,062
Accrued payroll and related taxes and benefits	265	2,462
Income taxes payable	99	260
Deferred revenue, net of related expenses	(442)	(1,062)
Accrued expenses	26,367	27,149
NET CASH PROVIDED BY OPERATING ACTIVITIES	27,419	17,856
INVESTING ACTIVITIES		
Purchases of patient service equipment and property, equipment and improvements, exclusive of effects of acquisitions	(36,909)	(44,783)
Proceeds from sale of patient service equipment and other	11,007	11,525
Cash paid for acquisitions		(94)
NET CASH USED IN INVESTING ACTIVITIES	(25,902)	(33,352)
FINANCING ACTIVITIES		
Proceeds from ABL Facility	146,000	67,000
Payments on ABL Facility	(159,000)	(57,000)
Payments on other long-term debt	(74)	(86)
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	(13,074)	9,914
NET DECREASE IN CASH AND CASH EQUIVALENTS	(11,557)	(5,582)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	27,080	29,096
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 15,523	$ 23,514

SUPPLEMENTAL DISCLOSURES See Note 5 and Note 8 for a discussion of cash paid for interest and income taxes, respectively.

Purchases of patient service equipment and property, equipment and improvements exclude purchases that remain unpaid at the end of the respective quarter. Such amounts are then included in the following period s purchases when paid. Unpaid purchases were $10.3 million and $15.0 million at March 31, 2013 and March 31, 2012, respectively.

See notes to unaudited condensed consolidated financial statements.

Table of Contents

APRIA HEALTHCARE GROUP INC.

NOTES TO UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

In the opinion of management, all adjustments, consisting of normal recurring accruals necessary for a fair presentation of the results of operations for the interim periods presented, have been reflected herein. The unaudited results of operations for interim periods are not necessarily indicative of the results to be expected for the entire year. For further information, refer to the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2012.

On October 28, 2008, the Company completed the Merger with Merger Sub, a Delaware corporation and wholly-owned subsidiary of Sky LLC. Buyer is controlled by private investment funds affiliated with the Sponsor.

Company Background: The Company operates in the home healthcare segment of the healthcare industry, providing a variety of high-quality clinical patient care management programs, related products and supplies as prescribed by a physician and/or authorized by a case manager as part of a care plan. Essentially all products and services offered by the Company are provided through the Company s network of approximately 520 locations, which are located throughout the United States. The Company provides services and products in two operating segments: home respiratory therapy/home medical equipment and home infusion therapy. Each operating segment constitutes a separate reporting unit and within these two operating segments there are four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including total parenteral nutrition (TPN), and enteral nutrition services. Both segments provide products and services in the home setting to patients and are primarily paid for by a third-party payor, such as Medicare, Medicaid, managed care or other third-party insurer. Sales for both segments are primarily derived from referral sources such as hospital discharge planners, medical groups or independent physicians.

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

Revenue Recognition and Concentration of Credit Risk: Revenues are recognized under fee-for-service/product arrangements for equipment the Company rents to patients, sales of equipment, supplies, pharmaceuticals and other items the Company sells to patients and under capitation arrangements with third party payors for services and equipment the Company provides to the patients of these payors. Revenue generated from equipment that the Company rents to patients is recognized over the rental period, typically one month, and commences on delivery of the equipment to the patients. Revenue related to sales of equipment, supplies and pharmaceuticals is recognized on the date of delivery to the patients. Revenues derived from capitation arrangements were approximately 7% of total net revenues for the three months ended March 31, 2013 and 2012. Capitation revenue is earned as a result of entering into a contract with a third party to provide its members certain services without regard to the actual services provided, therefore revenue is recognized in the period that the beneficiaries are entitled to healthcare services. All revenues are recorded at amounts estimated to be received under reimbursement arrangements with third-party payors, including private insurers, prepaid health plans, Medicare and Medicaid. Revenues reimbursed under arrangements with Medicare and Medicaid were approximately 29% of total net revenues for the three months ended March 31, 2013 and 30% for the three months ended March 31, 2012. No other third-party payor group represented more than 9% of the Company s revenues.

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

	Three Months Ended March 31,			
(dollars in millions)	**2013**		**2012**	
Rental	$ 168.7	29.6%	$ 166.6	30.2%
Sale	400.8	70.4	385.0	69.8

Total fee-for-service	$ 569.5	100.0%	$ 551.6	100.0%

Table of Contents

The Company provides various services and products to patients. These arrangements involve the sale of equipment, pharmaceuticals and medical supplies. Revenues from the sale of equipment, pharmaceuticals and medical supplies are recognized upon confirmation of delivery of the products. Additionally, the Company provides clinical nursing services to patients. Nursing services are recognized as revenue when the service is rendered.

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

Accounts Receivable: Included in accounts receivable are earned but unbilled receivables of $56.8 million at March 31, 2013 and December 31, 2012. Delays ranging from a day up to several weeks between the date of service and billing can occur due to delays in obtaining certain required payor-specific documentation from internal and external sources. Unbilled receivables can also be impacted by the transition of patients during the integration of acquisitions and overall revenue growth. Earned but unbilled receivables are aged from date of service and are considered in the analysis of historical performance and collectability.

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

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

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

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

Inventories: Inventories are stated at the lower of cost (first-in, first-out method) or market and consist primarily of pharmaceuticals and items used in conjunction with patient service equipment.

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

Property, Equipment and Improvements: Property, equipment and improvements are stated at cost less depreciation. Depreciation is provided using the straight-line method over the estimated useful lives of the assets, which range from one to fifteen years or for leasehold improvements the shorter of the useful life of the asset or the remaining life of the related lease.

Capitalized Software: Included in property, equipment and improvements are costs related to internally developed and purchased software that are capitalized and amortized over periods that the assets are expected to provide benefit. Capitalized costs include direct costs of materials and services incurred in developing or obtaining internal-use software and payroll and benefit costs for employees directly involved in the development of internal-use software. Additions to capitalized internally developed software totaled $2.0 million and $2.1 million for the three months ended March 31, 2013 and 2012, respectively.

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

Goodwill and indefinite-lived intangible assets are not amortized but instead tested at least annually for impairment, or more frequently when events or changes in circumstances indicate that the assets might be impaired. Goodwill is tested for impairment by comparing the carrying value to the fair value of the reporting unit to which the goodwill is assigned. A two-step test is used to

Table of Contents

identify the potential impairment and to measure the amount of impairment, if any. The first step is to compare the fair value of the reporting unit with its carrying amount, including goodwill. If the fair value of the reporting unit exceeds its carrying amount, goodwill is considered not impaired; otherwise, goodwill is impaired and the loss is measured by performing step two. Under step two, the impairment loss is measured by comparing the implied fair value of the reporting unit with the carrying amount of goodwill. Management has determined that our two operating segments are reporting units. As such, the Company has two reporting units: home respiratory therapy/home medical equipment and home infusion therapy. The Company performs the annual test for impairment as of the first day of its fourth quarter and determines fair value based on a combination of the income approach and the market approach. The income approach is based on discounted cash flows. The market approach uses a selection of comparable companies in determining market value. The fair values of trade names are also tested for impairment on the first day of its fourth quarter by comparing the carrying value to the fair value. Fair value of a trade name is determined using a relief from royalty method under the income approach, which uses projected revenue allocable to the trade name and an assumed royalty rate.

Long-lived assets, including property and equipment and purchased definite-lived intangible assets, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset or asset group may not be recoverable. Significant judgment is required in determining whether a potential indicator of impairment of long-lived assets exists and in estimating future cash flows for any necessary impairment tests. Recoverability of assets to be held and used is measured by the comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such an asset is considered to be impaired, the impairment to be recognized is measured as the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell.

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

Deferred Debt Issuance Costs: Capitalized debt issuance costs include those associated with the Company s Series A-1 Notes, Series A-2 Notes and Asset Based Revolving Credit Facility (ABL Facility). Such costs are classified as non-current assets. Costs relating to the ABL Facility are being amortized through the maturity date of August 2014. Costs relating to the Series A-1 Notes and Series A-2 Notes are amortized from the issuance date through October 2014. See Note 5 Long-term Debt and Note 13 Subsequent Events.

Fair Value of Financial Instruments: The carrying value of debt approximates fair value because the underlying instruments are variable notes that reprice frequently. The fair values of cash and cash equivalents, short-term investments and the Series A-1 Notes and Series A-2 Notes are determined based upon Level 1 inputs, consisting of quoted prices in active markets for identical items. The fair value of the Series A-1 Notes and Series A-2 Notes was $724.5 million and $327.0 million at March 31, 2013, respectively. The carrying amounts of cash and cash equivalents, accounts receivable, trade payables and accrued expenses approximate fair value due to their short maturity.

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

Home Respiratory Therapy Expenses: Home respiratory therapy expenses presented within cost of total net revenues are comprised primarily of employee salary and benefit costs or contract fees paid to respiratory therapists and other related professionals who are deployed to service a patient. Home respiratory therapy personnel are also engaged in a number of administrative and marketing tasks, and accordingly, these costs are classified within selling, distribution and administrative expenses and amounted to $8.5 million and $10.0 million in the three months ended March 31, 2013 and March 31, 2012, respectively.

Distribution Expenses: Distribution expenses are included in selling, distribution and administrative expenses and totaled $48.9 million and $49.9 million in the three months ended March 31, 2013 and March 31, 2012, respectively. Such expense represents the cost incurred to coordinate and deliver products and services to the patients. Included in distribution expenses are leasing, maintenance, licensing and fuel costs for the vehicle fleet; salaries and other costs related to drivers and dispatch personnel; and amounts paid to courier and other outside shipping vendors. Such expenses fall within the definition of shipping and handling costs and are classified within selling and administrative expenses and may not be comparable to other companies.

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

9

Table of Contents

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

(in thousands)	March 31, 2013	December 31, 2012
Workers compensation	$ 10,861	$ 10,927
Professional and general liability/vehicle	3,528	3,773
Medical insurance	4,604	6,608

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

(in thousands)	March 31, 2013	December 31, 2012
Workers compensation	$ 33,129	$ 33,130
Professional and general liability/vehicle	7,906	8,565

Income Taxes: The Company s provision for income taxes is based on expected income, permanent book/tax differences and statutory tax rates in the various jurisdictions in which the Company operates. Significant management estimates and judgments are required in determining the provision for income taxes.

Profit Interest Units: The Company measures and recognizes compensation expense for all profit interest unit awards made to employees based on estimated fair values on the date of grant. The value of the portion of the award that is ultimately expected to vest is recognized as expense over the requisite service period in the Company s consolidated financial statements. Forfeitures are estimated at the time of grant and revised, if necessary, in subsequent periods if actual forfeitures differ from those estimates. Profit interest unit expense is recognized on a straight-line basis over the requisite service period. The estimate of fair value of profit interest unit awards on the date of grant is determined through the allocation of all outstanding securities to a business enterprise valuation. The enterprise valuation is based upon a combination of the income approach and the market approach. The income approach is based on discounted cash flows. The market approach uses a selection of comparable companies in determining value. This determination of fair value is affected by assumptions regarding a number of highly complex and subjective variables. Changes in the subjective assumptions can materially affect the estimate of their fair value.

Recent Accounting Pronouncements: In December 2011, the Financial Accounting Standards Board (FASB) issued guidance enhancing disclosure requirements about the nature of an entity s right to offset and related arrangements associated with its financial instruments and derivative instruments. The new guidance requires the disclosure of the gross amounts subject to rights of set-off, amounts offset in accordance with the accounting standards followed, and the related net exposure. The new guidance will be effective for us beginning July 1, 2013. Other than requiring additional disclosures, the Company does not anticipate material impacts on its financial statements upon adoption.

NOTE 2 RESTATEMENT OF CONSOLIDATED FINANCIAL STATEMENTS

Historically, the Company accounted for cash receipts from the sale of patient service equipment in operating activities in its consolidated statements of cash flows. Subsequent to the issuance of the 2011 financial statements, the Company concluded that the cash receipts from the sale of patient service equipment should be recorded in investing activities on the Company s consolidated statements of cash flows. Accordingly, the Company has restated its consolidated statements of cash flows for the three months ended March 31, 2012. The impact of the restatement decreased net cash provided by operating activities in the Company s consolidated statements of cash flows by $11.5 million or 39.2% the three months ended March 31, 2012. Additionally, net cash used in investing activities in the Company s consolidated statements of cash flows decreased by $11.5 million or 25.7% in the three months ended March 31, 2012. There is no change to the total cash flows in the three months ended March 31, 2012.

The following tables show the impact of the restatement.

CONSOLIDATED STATEMENT OF CASH FLOWS ITEMS

Three Months Ended March 31, 2012

(in thousands)	(As Previously Reported)	(Adjustments)	(As Restated)
Loss (Gain) on sale of patient service equipment and other	$ 5,597	$ (11,512)	$ (5,915)
Net cash provided by operating activities	29,368	(11,512)	17,856
Proceeds from sale of patient service equipment and other	13	11,512	11,525
Net cash used in investing activities	$ (44,864)	$ 11,512	$ (33,352)

Table of Contents

The restatement described above did not impact the Company s consolidated statements of operations or total cash flows for three months ended March 31, 2012.

NOTE 3 BUSINESS COMBINATIONS

The Company periodically acquires complementary businesses. The results of operations of the acquired companies are included in the accompanying condensed consolidated statements of operations from the dates of acquisition.

During the three months ended March 31, 2013 there were no acquisitions. During the three months ended March 31, 2012, the Company purchased certain assets and businesses for total consideration $0.1 million.

NOTE 4 GOODWILL AND INTANGIBLE ASSETS

Changes in goodwill by segment are as follows:

(in thousands)	Home Infusion Therapy	Home Respiratory Therapy and Home Medical Equipment	Total
Balance, December 31, 2012	$ 258,725	$	$ 258,725
Acquisitions			
Balance, March 31, 2013	$ 258,725	$	$ 258,725

The Company recorded a non-cash impairment charge of $350.0 million related to intangible assets in the year ended December 31, 2012, of which $270.0 million related to the home respiratory therapy/home medical equipment reporting unit and $80.0 million related to the enteral business, which is part of the home infusion therapy reporting unit.

Intangible assets consist of the following:

		March 31, 2013			December 31, 2012			
(dollars in thousands)	Average Life in Years	Gross Carrying Amount	Accumulated Amortization	Net Book Value	Gross Carrying Amount	Accumulated Amortization	Impairment Charge	Net Book Value
Intangible assets subject to amortization:								
Capitated relationships	20.0	$ 4,400	$ (1,376)	$ 3,024	$ 4,400	$ (1,327)		$ 3,073
Payor relationships	20.0	11,000	(2,429)	8,571	11,000	(2,292)		8,708
Net favorable leasehold interest								
Customer list	0.9				121	(121)		
Subtotal		15,400	(3,805)	11,595	15,521	(3,740)		11,781
Intangible assets not subject to amortization:								
Trade names		115,000		115,000	465,000		(350,000)	115,000
Accreditations with commissions		7,000		7,000	7,000			7,000
Subtotal		122,000		122,000	472,000			122,000

Total	$ 137,400	$ (3,805)	$ 133,595	$ 487,521	$ (3,740)	$ (350,000)	$ 133,781

Table of Contents

Amortization expense amounted to $0.2 million and $0.7 million for the three months ended March 31, 2013 and 2012, respectively. Estimated amortization expense for each of the fiscal years ending December 31 is presented below:

Year Ending December 31,	(in thousands)
2013	$ 744
2014	744
2015	744
2016	744
2017	744
Thereafter	8,060

NOTE 5 LONG-TERM DEBT

Series A-1 Notes and Series A-2 Notes. Series A-1 Notes and Series A-2 Notes were issued by Apria in May 2009 and August 2009, respectively. On April 5, 2013, all Series A-1 Notes and $160.0 million of Series A-2 Notes were refinanced. See Note 13 Subsequent Events. The Series A-1 Notes and the Series A-2 Notes bear interest at a rate equal to 11.25% per annum and 12.375% per annum, respectively. The indenture governing the Series A-1 Notes and the Series A-2 Notes, among other restrictions, limits Apria s ability and the ability of its restricted subsidiaries to:

incur additional debt;

pay dividends and make other distributions;

make certain investments;

repurchase the Company stock;

incur certain liens;

enter into transactions with affiliates;

merge or consolidate;

enter into agreements that restrict the ability of the Company s subsidiaries to make dividends or other payments to us; and

transfer or sell assets.

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

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

Series A-1 Notes	Percentage
November 1, 2011	105.625%
November 1, 2012	102.813%
November 1, 2013 and thereafter	100.000%

Series A-2 Notes	Percentage
November 1, 2011	106.188%
November 1, 2012	103.094%
November 1, 2013 and thereafter	100.000%

Substantially all of Apria s 100% owned subsidiaries (the Guarantors) jointly and severally, unconditionally guarantee the $700 million Series A-1 Notes and the $317.5 million Series A-2 Notes on a senior secured basis. The Guarantors also guarantee Apria s ABL Facility.

Amended and Restated ABL Facility: On August 8, 2011, we entered into a senior secured asset-based revolving credit facility, or ABL Facility, with Bank of America, N.A., as administrative agent and collateral agent and a syndicate of financial institutions and

Table of Contents

institutional lenders. The ABL Facility amended and restated our prior senior secured asset-based revolving credit facility dated October 28, 2008, which provided for a revolving credit financing of up to $150.0 million.

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

Borrowings under our ABL Facility bear interest at a rate per annum equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 1/2 of 1% (Base Rate), plus an applicable margin (currently 1.25%) or (b) a LIBOR rate determined by reference to LIBOR, adjusted for statutory reserve requirements, plus an applicable margin (currently 2.25%). The applicable margin for borrowings under our ABL Facility is subject to (a) 25 basis points step ups and step downs based on average excess availability under the ABL Facility and (b) a step down of 25 basis points based on achieving a consolidated fixed charge coverage ratio greater than 1.75 to 1.00. In addition to paying interest on outstanding amounts under our ABL Facility, we are required to pay a commitment fee, in respect of the unutilized commitments thereunder, ranging from 0.375% to 0.50% per annum, which fee will be determined based on utilization of our ABL Facility (increasing when utilization is low and decreasing when utilization is high). We also pay customary letter of credit fees equal to the applicable margin on LIBOR loans and other customary letter of credit and agency fees.

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

As of March 31, 2013, there was $12.0 million outstanding under the ABL Facility, outstanding letters of credit totaled $23.6 million and additional availability under the ABL Facility, subject to the borrowing base, was $214.4 million. As of March 31, 2013, the available borrowing base did not constrain our ability to borrow the entire $214.4 million available borrowing capacity under our ABL Facility. At March 31, 2013, we were in compliance with all of the financial covenants required by the credit agreement governing the ABL Facility. As of April 26, 2013, there was approximately $55.0 million outstanding under the ABL Facility.

Interest paid on debt totaled $0.7 million and $0.6 million for the three months ended March 31, 2013 and 2012, respectively. Interest expense for the three months ended March 31, 2013 and 2012 was $34.2 million and $33.5 million, respectively. Accrued interest was $49.6 million and $19.9 million as of March 31, 2013 and December 31, 2012, respectively recorded in accrued liabilities.

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

NOTE 6 STOCKHOLDERS DEFICIT

For the three months ended March 31, 2013, changes to stockholders deficit were comprised of the following amounts (in thousands):

	Common Stock	Additional Paid In Capital	Accumulated Deficit	Total Stockholders Deficit
Balance as of December 31, 2012	$	$ 695,211	$ (1,026,635)	$ (331,424)
Net loss			(1,893)	(1,893)
Profit interest compensation		1,321		1,321
Balance as of March 31, 2013	$	$ 696,532	$ (1,028,528)	$ (331,996)

NOTE 7 PROFIT INTEREST UNITS

Profit Interest Units: In November and December of 2008, BP Healthcare Holdings LLC (BP Holdings) and Sky LLC, parent entities of the Company affiliated with the Sponsor, granted equity units to the Company s former Chief Executive Officer and the Company s former Chief Financial Officer for purposes of retaining them and enabling such individuals to participate in the long-term growth and financial success of the Company. In addition, in 2009, 2010 and 2011, Sky LLC (and following the Company s

Table of Contents

reorganization in March 2010, Apria Holdings LLC) granted equity units to certain management employees for purposes of retaining them and enabling such individuals to participate in the long-term growth and financial success of the Company. Profit interest units are measured at the grant date, based on the calculated fair value of the award, and are recognized as an expense over the employee s requisite service period. These equity awards were issued in exchange for services to be performed.

In November 2008, BP Holdings granted Norman C. Payson, M.D., who was then the Company s Chief Executive Officer, 38,697,318 Class B units, all of which were subject to vesting terms based on either (i) continued service to BP Holdings or its subsidiaries and/or (ii) performance/market conditions.

Time-Vesting Units. The portion of the Class B units that vest based on continued service represent 80% of the total Class B units. These units vest over four years starting on October 28, 2008 based on continued service, but will become fully vested on an accelerated basis either (x) upon a change in control while the Company s Chief Executive Officer continues to provide services to BP Holdings or its subsidiaries or (y) if affiliates of the Sponsor receive cash proceeds in respect to 50% of their units in BP Holdings equal to at least 200% of their aggregate capital contributions in respect of such units while the Company s Chief Executive Officer continues to provide services to BP Holdings or its subsidiaries. In addition, if the Company s Chief Executive Officer s services are terminated (a) by the Company without cause or (b) by the Chief Executive Officer as a result of constructive termination, an additional number of these time-vesting Class B units will vest equal to the number that would have vested over the 24-month period following the applicable termination date. Any of these time-vesting Class B units that are unvested on termination of the executive s services will be forfeited. These units were fully vested as of December 31, 2012.

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

Assumptions used were as follows:

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

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

On November 29, 2012, Norman C. Payson, M.D. announced his retirement from his position as Chief Executive Officer and Chairman of the Board of Directors. Dr. Payson will remain on the Company s Board of Directors and serve as a senior advisor to the Company. In connection with Dr. Payson s retirement, the Board of Directors determined that in order to retain Dr. Payson s continued services it was appropriate to amend the terms of his existing performance-vesting Class B Units to, among other things, provide that (1) his performance-vesting Class B Units will become time-vesting units and will vest in equal monthly installments over a two-year period commencing on November 29, 2012 (or an earlier termination of his services) regardless of whether the existing performance-vesting conditions are met during such time and (2) his performance-vesting Class B units will become fully vested on an accelerated basis upon (x) a change in control while he continues to serve as an advisor or director or (y) if his advisory or board services are terminated without cause or if he resigns as a result of a constructive termination on or prior to November 29, 2014. In addition, Dr. Payson was granted an additional 3,830,365 time-vesting Class B Units which will generally vest in equal installments every three months over a period of four years from the grant date.

14

Table of Contents

The following table summarizes activity for profit interest units for the period December 31, 2012 to March 31, 2013:

	Class B Units
Balance at December 31, 2012	42,527,683
Granted	
Exercised	
Forfeited	
Balance at March 31, 2013	42,527,683
Vested units at March 31, 2013	32,487,163

There is no stated contractual life for the B units.

In December 2008, Sky LLC granted to Chris A. Karkenny, who was then the Company s Chief Financial Officer, 500,000 Class A-2 units, 6,675,287 Class B units and 2,225,096 Class C units, all of which were subject to vesting terms based on either (i) continued service to Sky LLC or its subsidiaries or (ii) performance/market conditions.

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

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

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

Assumptions used were as follows:

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

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

On December 28, 2012, it was announced that announced that Chris A. Karkenny, the Company s Executive Vice President and Chief Financial Officer, would leave the Company effective as of December 31, 2012 to pursue other business opportunities. In connection with Mr. Karkenny s termination of employment, the Board of Directors determined to amend his management unit subscription agreement to (1) provide that his performance-vesting Class B and Class C Units would not be forfeited as a result of his termination of employment and instead will remain

eligible to vest if the performance conditions are satisfied prior to March 31, 2014 and (2) provide that his vested units can only be purchased by the Company during the period from March 31, 2014 to June 1, 2014. Mr. Karkenny forfeited 667,529 units, which were unvested time-vesting units on the date of his departure.

Table of Contents

The following table summarizes activity for profit interest units for the period December 31, 2012 to March 31, 2013:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2012	500,000	6,007,758	2,225,096
Exercised			
Forfeited			
Balance at March 31, 2013	500,000	6,007,758	2,225,096
Vested units at March 31, 2013		3,782,284	

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

Sky LLC (and following the Company s reorganization in March 2010, Apria Holdings LLC) granted certain management employees 64,702,929 Class B units and 18,416,092 Class C units, all of which are subject to vesting terms based on either (i) continued service to Sky LLC or its subsidiaries or (ii) performance/market conditions.

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

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

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

Assumptions used were as follows for the 2010 grants:

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

Assumptions used were as follows for the 2011 grants:

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

Assumptions used were as follows for the 2012 grants:

Expected Asset Volatility(1)	25.0%

Risk Free Interest Rate(2)	0.83%
Expected Life(3)	5.0 years

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

Table of Contents

The following table summarizes activity for profit interest units for the period December 31, 2012 to March 31, 2013:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2012	1,075,000	42,852,564	11,078,113
Granted			
Forfeited		(986,782)	(328,927)
Balance at March 31, 2013	1,075,000	41,865,782	10,749,186
Vested units at March 31, 2013		13,671,984	

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

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

Apria Holdings LLC granted the new Board member, Mr. Zafirovski, 5,030,651 Class B units in October 2011, all of which are subject to vesting terms based on either (i) continued service or (ii) performance/market conditions.

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

Performance-Vesting Units. The remaining portion of the Class B units vest based on performance/market conditions. These units are divided into two categories, with vesting in each category based on the Company s achievement of EBITDA (as defined in the Company s credit agreement) targets and return on the investment of the Sponsor (defined as Blackstone Capital Partners V L.P. and its affiliates). The first category of the target-based Class B Units will vest if either of the following conditions is satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after termination by the Company of his service on the Board of Directors without cause): (1) the Company achieves a specified EBITDA target for each of fiscal year 2012 and fiscal year 2013; or (2) the Sponsor achieves a specified return on investment on or prior to December 31, 2014. The second category of the target-based Class B Units will vest if both of the following conditions are satisfied while Mr. Zafirovski continues to serve as a director (or within 24 months after a termination by the Company of his service on the Board of Directors without cause): (1) the Company achieves a more challenging specified EBITDA target for either fiscal year 2012 or fiscal year 2013 (such year of achievement, the Subject Year); and (2) one of the following conditions is satisfied: (a) the Company achieves a more challenging specified EBITDA target for the fiscal year immediately succeeding the Subject Year; or (b) the Sponsor achieves a specified return on investment on or prior to December 31, 2014. The Company believes that the targets set for the target based Class B Units are reasonable, although neither automatically nor easily achieved.

The Class B units acquired by Mr. Zafirovski are similar to the other Class B units, except that the Class B units granted to Mr. Zafirovski contain a special term that would require the value of Holdings Class A-2 Units to exceed $1.63 for him to receive any value, such that no payment would be made in respect of a Class B Unit if the value of a Class A-2 Unit fails to exceed $1.63.

Assumptions used were as follows for the 2011 grants:

Expected Asset Volatility(1)	25.0%

Risk Free Interest Rate(2)	2.01%
Expected Life(3)	5.0 years

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

Table of Contents

The following table summarizes activity for profit interest units for the period December 31, 2012 to March 31, 2013:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2012	1,000,000	5,030,651	
Granted			
Balance at March 31, 2013	1,000,000	5,030,651	
Vested units at March 31, 2013		558,956	

In December 2012, BP Holdings and the new Chief Executive Officer and Chairman of the Board of Directors, Mr. Figueroa, entered into a management unit subscription agreement pursuant to which Mr. Figueroa purchased 1,000,000 Class A-2 Units of Holdings at the price of $1.00 per unit. He also has the right, but not the obligation, to purchase up to an additional 9,814,533 Class A-2 Units for a period of six months following December 5, 2012, the date of his initial purchase. The Class A-2 Units purchased by Mr. Figueroa were fully vested when purchased and contain different economic terms than Holdings normal Class A-2 Units which will not entitle him to receive any value above $1.00 per Class A-2 Unit unless and until the cumulative value attributable to each of his Class A-2 Units exceeds $1.10, at which point the special Class A-2 Units will become entitled to receive $0.10 per unit and thereafter will become entitled to receive the same amount as other Class A-2 Units.

BP Holdings granted Mr. Figueroa 12,257,169 Class B Units, all of which are subject to vesting terms based on continued service to BP Holdings or its subsidiaries. The Class B Units granted to Mr. Figueroa contain a special term that requires the value of Holdings Class A Units to exceed $1.10 in order for him to receive any value from such units, such that no payment will be made in respect of his Class B Units if the value a Class A Unit fails to exceed $1.10.

Time Vesting Units. All of Mr. Figueroa s Class B Units are time-vesting, with 20% of the Class B Units vesting on December 5, 2013 and an additional 5% of the Class B Units vesting every three months for a period of four years thereafter. The Class B Units will become fully vested if a change in control of Holdings occurs while Mr. Figueroa is still employed with the Company. Any Class B Units that are unvested upon termination of Mr. Figueroa s employment will be forfeited.

Assumptions used were as follows:

Expected Asset Volatility(1)	25.0%
Risk Free Interest Rate(2)	0.83%
Expected Life(3)	5.0 years

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

The following table summarizes activity for profit interest units for the period December 31, 2012 to March 31, 2013:

	Class A-2 Units	Class B Units	Class C Units
Balance at December 31, 2012	1,000,000	12,257,169	
Granted			
Forfeited			
Balance at March 31, 2013	1,000,000	12,257,169	

Vested units at March 31, 2013	

Expense recorded related to all profit interest units was $1.3 million and $0.7 million in the three months ended March 31, 2013 and 2012, respectively. As of March 31, 2013, total unrecognized profit interest compensation cost related to unvested profit interest units was $10.1 million, which is expected to be expensed over a weighted average period of 3.7 years. The total fair market value of shares vested was $0.9 million and $1.1 million in the three months ended March 31, 2013 and 2012, respectively.

Table of Contents

The following table summarizes activity for all profit interest units for the period December 31, 2012 to March 31, 2013:

	Class A-2 Shares	Weighted-Average Grant Date Fair Value	Class B Units	Weighted-Average Grant Date Fair Value	Class C Units	Weighted-Average Grant Date Fair Value
Balance at December 31, 2012	3,575,000	0.81	108,675,825	0.37	13,303,209	0.21
Granted						
Forfeited			(986,782)	0.35	(328,927)	0.20
Balance at March 31, 2013	3,575,000	0.81	107,689,043	0.37	12,974,282	0.21

NOTE 8 INCOME TAXES

The Company s effective tax rate was (15.5)% for the three months ended March 31, 2013, compared to (4.8)% for the three months ended March 31, 2012. For the three months ended March 31, 2013 and 2012, the Company s effective tax rate differed from federal and state statutory rates primarily due to the accrual of a valuation allowance against substantially all of the Company s net deferred tax assets.

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

Beginning with the year ended December 31, 2011, the Company accrued a valuation allowance against substantially all of its net deferred tax assets since the Company determined that it is more likely than not that substantially all of the its net deferred tax assets will not be realized. The Company intends to maintain its valuation allowance until sufficient positive evidence exists to support the reversal of all or a portion of its valuation allowance.

The Company increased its valuation allowance by $0.3 million to $238.8 million at March 31, 2013 from $238.5 million at December 31, 2012 to offset corresponding increases in its net deferred tax assets for the three months ended March 31, 2013.

The Company accounts for its tax uncertainties under generally accepted accounting principles. Accordingly, the Company is required to disclose certain information, within its interim financial statements, when material changes occur regarding its tax uncertainties. For the three months ended March 31, 2013, no material changes occurred with respect to the Company s tax uncertainties which would require disclosure.

As of March 31, 2013, federal net operating loss (NOLs) carryforwards of approximately $434.2 million were available to offset future federal taxable income. Such NOLs will expire at various times and in varying amounts during the Company s calendar 2015 through 2033 tax years. A significant portion of these NOLS are subject to an annual utilization limitation as required by Section 382 of the Internal Revenue Code of 1986, as amended.

The Company files federal and state income tax returns in jurisdictions with varying statutes of limitations expiration dates. The Company s calendar 2009 through 2012 tax years generally remain subject to examination by tax authorities. The Internal Revenue Service (IRS) has recently completed its audit of the Company s calendar 2009 Federal income tax return and made immaterial changes to the Company s NOL carryforwards. Certain state tax agencies are currently examining the tax years 2006 and forward.

Net income tax payments made (and refunds received) for the three-month period ended March 31, 2013 and 2012 amounted to $0.3 million and $0.3 million, respectively.

NOTE 9 COMMITMENTS AND CONTINGENCIES

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

Medicare and Medicaid Reimbursement: There are a number of provisions contained within recent, proposed or contemplated legislation that affect or may affect Medicare and Medicaid reimbursement policies for items and services provided. The Company cannot be certain of the ultimate impact of all legislated and contemplated changes, and therefore cannot provide assurance that these changes will not have a material adverse effect on the Company s financial condition or results of operations.

Table of Contents

Supplier Concentration: Currently, approximately 71.3% of purchases for patient service equipment and supplies are from five vendors. Although there are a limited number of suppliers, management believes that other vendors could provide similar products on comparable terms. However, a change in suppliers could cause delays in service delivery and possible losses in revenue, which could adversely affect the Company s financial condition or operating results.

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

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

NOTE 10 SEGMENTS

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

Segment financial results are based on directly assignable net revenues, cost of goods sold, bad debt expenses and selling, distribution and administrative costs, where available. Costs that are not directly assignable, such as corporate costs and certain selling, distribution and administrative expenses, are allocated based on various metrics including billed census, headcount and branch locations by segment, among others.

During the fourth quarter of 2012, the Company revised its allocation to its reporting segments. This allocation is based on how the Company currently manages and discusses its operations.

	Net Revenue Three Months Ended March 31,	
(in thousands)	**2013**	**2012**
Operating Segment		
Home Respiratory Therapy and Home Medical Equipment	$ 298,525	$ 300,898
Home Infusion Therapy	316,230	294,815
Total	$ 614,755	$ 595,713

	EBIT Three Months Ended March 31,	
(in thousands)	**2013**	**2012**
Operating Segment		
Home Respiratory Therapy and Home Medical Equipment	$ 584	$ (16,000)
Home Infusion Therapy	31,479	30,106
Total	$ 32,063	$ 14,106

Table of Contents

(in thousands)	Depreciation and Amortization Three Months Ended March 31, 2013	2012
Operating Segment		
Home Respiratory Therapy and Home Medical Equipment	$ 22,596	$ 24,965
Home Infusion Therapy	3,951	4,401
Total	$ 26,547	$ 29,366

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

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

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

(in thousands)	Three Months Ended March 31, 2013	2012
Net loss	$ (1,893)	$ (19,607)
Interest expense, net (a)	33,702	32,815
Income tax benefit	254	898
EBIT	$ 32,063	$ 14,106

(a) Reflects $34.2 million of interest expense, net of $0.5 million of interest income for the three months ended March 31, 2013. Reflects $33.5 million of interest expense, net of $0.7 million of interest income for the three months ended March 31, 2012.

The Company allocates certain corporate expenses that are not directly attributable to a product line based upon Company metrics. For the three months ended March 31, 2013, the corporate costs allocated to the home respiratory therapy/home medical equipment segment were $30.2 million and the corporate costs allocated to the home infusion therapy segment were $14.3 million. For the three months ended March 31, 2012, the corporate costs allocated to the home respiratory therapy/home medical equipment segment were $37.6 million and the corporate costs allocated to the home infusion therapy segment were $12.6 million.

NOTE 11 CERTAIN RELATIONSHIPS AND RELATED PARTY TRANSACTIONS

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

securities), financing or similar transaction by the Company.

At any time in connection with or in anticipation of a change of control of the Company, a sale of all or substantially all of the Company s assets or an initial public offering of common equity of the Company or its successor, BMP may elect to receive, in consideration of BMP s role in facilitating such transaction and in settlement of the termination of the services, a single lump sum

Table of Contents

cash payment equal to the then-present value of all then-current and future annual management fees payable under the transaction and management fee agreement, assuming a hypothetical termination date of the agreement to be the twelfth anniversary of such election. The transaction and management fee agreement will continue until the earlier of the twelfth anniversary of the date of the agreement or such date as the Company and BMP may mutually determine. The Company has agreed to indemnify BMP and its affiliates, directors, officers, employees, agents and representatives from and against all liabilities relating to the services contemplated by the transaction and management fee agreement and the engagement of BMP pursuant to, and the performance of BMP and its affiliates of the services contemplated by, the transaction and management fee agreement. In accordance with the management agreement, the Company expensed $1.8 million for both the quarter ended March 31, 2013 and 2012.

Intelenet Agreement: In May 2009, the Company entered into the Master Services Agreement (the Intelenet Agreement) with Intelenet Global Services Private Limited (Intelenet), an Indian company then-affiliated with the Sponsor, regarding the outsourcing of certain functions relating to billing, collections and other administrative and clerical services. In July 2011 an affiliate of the Sponsor, along with other shareholders of Intelenet, sold Intelenet to Serco Group PLC, an international services company. During the three months ended March 31, 2013 and March 31, 2012, the Company paid approximately $3.9 million and $4.1 million, respectively, to Intelenet. The Company continues to rely on Intelenet to perform certain administrative functions, but other administrative functions included in the original Intelenet Agreement are now incorporated into our internal Company-run customer care centers and branch operations staffed with our personnel.

Equity Healthcare Agreement: Effective as of January 1, 2010, the Company entered into an employer health program agreement with Equity Healthcare LLC (Equity Healthcare), an affiliate of the Sponsor, pursuant to which Equity Healthcare will provide to the Company certain negotiating, monitoring and other services in connection with our health benefit plans. Because of the combined purchasing power of its client participants, Equity Healthcare is able to negotiate pricing terms for providers that are believed to be more favorable than the companies could obtain for themselves on an individual basis. In consideration for Equity Healthcare s services, the Company will pay Equity Healthcare a fee of $2 per participating employee per month (the PEPM Fee). The Company entered into an amended agreement with Equity Healthcare on December 22, 2011, and in consideration for Equity Healthcare s services, the Company will pay Equity Healthcare a PEPM fee of $2.25 or $2.50 in 2012, and $2.35 or $2.60 in 2013, depending upon whether the Company s employees are enrolled in a grandfathered or custom health benefit plan. As of March 31, 2013, the Company had approximately 7,400 employees enrolled in Equity Healthcare health benefit plans.

NOTE 12 FINANCIAL GUARANTEES

The Company conducts substantially all of its business through its subsidiaries. Substantially all of the Company s 100%-owned subsidiaries, jointly and severally, unconditionally guarantee the Series A-2 Notes on a senior secured basis. The Guarantors also guarantee the Company s ABL Facility. See also Note 5 Long-Term Debt.

The following condensed consolidating financial statements quantify the financial position as of March 31, 2013 and December 31, 2012, the operations for the three months ended March 31, 2013 and 2012, and the cash flows for the three months ended March 31, 2013 and 2012. These condensed consolidating financial statements present financial information for the parent issuer, the guarantor subsidiaries, the non-guarantor subsidiaries and consolidating adjustments, consisting of the entries that eliminate the investment in subsidiaries and intercompany balances and transactions.

The financial information as presented below is based on estimates to bifurcate shared resources, costs and revenues between entities and such information may not be indicative of results, if separate financial statements were prepared for these subsidiaries.

Table of Contents

CONDENSED CONSOLIDATING BALANCE SHEETS

March 31, 2013

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	$ 17,287	$	$ 384	$ (2,148)	$ 15,523
Accounts receivable less allowance for doubtful accounts		348,451	1,426		349,877
Inventories, net		70,914	286		71,200
Deferred expenses		3,701			3,701
Intercompany	308,405	905,125		(1,213,530)	
Prepaid expenses and other current assets	1,326	21,852	12		23,190
Intercompany loan	710,000			(710,000)	
TOTAL CURRENT ASSETS	1,037,018	1,350,043	2,108	(1,925,678)	463,491
PATIENT SERVICE EQUIPMENT, less accumulated depreciation		190,479	3		190,482
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	36,720	37,612	166		74,498
GOODWILL		258,725			258,725
INTANGIBLE ASSETS, NET	50,000	83,595			133,595
DEFERRED DEBT ISSUANCE COSTS, NET	26,373				26,373
INVESTMENT IN SUBSIDIARIES		925		(925)	
OTHER ASSETS	6,281	21,891			28,172
TOTAL ASSETS	$ 1,156,392	$ 1,943,270	$ 2,277	$ (1,926,603)	$ 1,175,336
LIABILITIES AND STOCKHOLDERS (DEFICIT) EQUITY					
CURRENT LIABILITIES					
Accounts payable	$ 1,768	$ 147,431	$ 188	$ (2,148)	$ 147,239
Accrued payroll and related taxes and benefits	5,931	64,703	177		70,811
Deferred income taxes current	4,534	(1,804)			2,730
Other accrued liabilities	49,582	51,447	60		101,089
Deferred revenue		27,246			27,246
Intercompany	54,937	1,158,593		(1,213,530)	
Current portion of long-term debt	12,000	710,136		(710,000)	12,136
TOTAL CURRENT LIABILITIES	128,752	2,157,752	425	(1,925,678)	361,251
LONG-TERM DEBT, net of current portion	1,017,500				1,017,500
DEFERRED INCOME TAXES	14,266	53,273			67,539
INVESTMENT IN SUBSIDIARIES	320,450			(320,450)	
INCOME TAXES PAYABLE & OTHER NON-CURRENT LIABILITIES	7,420	52,695	927		61,042
TOTAL LIABILITIES	1,488,388	2,263,720	1,352	(2,246,128)	1,507,332
COMMITMENTS AND CONTINGENCIES					
STOCKHOLDERS (DEFICIT) EQUITY					
Additional paid-in capital	696,532	(217,570)		217,570	696,532
(Accumulated deficit) retained earnings	(1,028,528)	(102,880)	925	101,955	(1,028,528)

TOTAL STOCKHOLDERS	(DEFICIT) EQUITY	(331,996)	(320,450)	925	319,525	(331,996)
		$ 1,156,392	$ 1,943,270	$ 2,277	$ (1,926,603)	$ 1,175,336

Table of Contents

CONDENSED CONSOLIDATING BALANCE SHEETS

December 31, 2012

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
ASSETS					
CURRENT ASSETS					
Cash and cash equivalents	$ 23,457	$ 3,354	$ 269	$	$ 27,080
Accounts receivable less allowance for doubtful accounts		343,100	1,321		344,421
Inventories		67,857	218		68,075
Deferred expenses		3,798			3,798
Intercompany	667,745	475,973		(1,143,718)	
Prepaid expenses and other current assets	835	16,043	12		16,890
Intercompany loan	710,000			(710,000)	
TOTAL CURRENT ASSETS	1,402,037	910,125	1,820	(1,853,718)	460,264
PATIENT SERVICE EQUIPMENT, less accumulated depreciation		186,457	3		186,460
PROPERTY, EQUIPMENT AND IMPROVEMENTS, NET	37,210	39,430	183		76,823
GOODWILL		258,725			258,725
INTANGIBLE ASSETS, NET	50,000	83,781			133,781
DEFERRED DEBT ISSUANCE COSTS, NET	30,207				30,207
INVESTMENT IN SUBSIDIARIES		774		(774)	
OTHER ASSETS	5,390	21,058			26,448
TOTAL ASSETS	$ 1,524,844	$ 1,500,350	$ 2,006	$ (1,854,492)	$ 1,172,708
LIABILITIES AND STOCKHOLDERS EQUITY					
CURRENT LIABILITIES					
Accounts payable	$ 4,751	$ 152,593	$ 186	$	$ 157,530
Accrued payroll and related taxes and benefits	8,774	61,562	211		70,547
Deferred income taxes	3,578	(2,592)			986
Other accrued liabilities	19,883	54,536	45		74,464
Deferred revenue		27,785			27,785
Intercompany	402,475	741,243		(1,143,718)	
Current portion of long-term debt	25,000	710,195		(710,000)	25,195
TOTAL CURRENT LIABILITIES	464,461	1,745,322	442	(1,853,718)	356,507
LONG-TERM DEBT, net of current portion	1,017,500	15			1,017,515
DEFERRED INCOME TAXES	15,222	53,685			68,907
INVESTMENT IN SUBSIDIARIES	351,927			(351,927)	
INCOME TAXES PAYABLE & OTHER NON-CURRENT LIABILITIES	7,158	53,255	790		61,203
TOTAL LIABILITIES	1,856,268	1,852,277	1,232	(2,205,645)	1,504,132
COMMITMENTS AND CONTINGENCIES					
STOCKHOLDERS EQUITY					
Common stock					

Additional paid-in capital	695,211	(247,215)		247,215	695,211
(Accumulated deficit) retained earnings	(1,026,635)	(104,712)	774	103,938	(1,026,635)
TOTAL STOCKHOLDERS (DEFICIT) EQUITY	(331,424)	(351,927)	774	351,153	(331,424)
	$ 1,524,844	$ 1,500,350	$ 2,006	$ (1,854,492)	$ 1,172,708

Table of Contents

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

Three Months Ended March 31, 2013

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
Operating net revenue	$	$ 613,114	$ 2,152	$ (511)	$ 614,755
Income from subsidiaries	53,899			(53,899)	
TOTAL NET REVENUES	53,899	613,114	2,152	(54,410)	614,755
TOTAL COST OF NET REVENUES		259,466	1,267	(511)	260,222
Provision for doubtful accounts		23,241	(106)		23,135
Selling, distribution and administrative	37,270	315,083	695	(53,899)	299,149
Amortization of intangible assets		186			186
TOTAL COSTS AND EXPENSES	37,270	597,976	1,856	(54,410)	582,692
OPERATING INCOME	16,629	15,138	296		32,063
Interest expense	34,202	10			34,212
Interest income and other	(15,376)	14,721	145		(510)
(LOSS) INCOME BEFORE TAXES	(2,197)	407	151		(1,639)
Income tax (benefit) expense	280	(26)			254
NET (LOSS) INCOME	(2,477)	433	151		(1,893)
Equity in income of subsidiaries, net of tax	584	151		(735)	
NET (LOSS) INCOME	$ (1,893)	$ 584	$ 151	$ (735)	$ (1,893)

Table of Contents

CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS

Three Months Ended March 31, 2012

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
Operating net revenue	$	$ 593,408	$ 2,482	$	$ 595,890
Income from subsidiaries	60,388			(60,565)	(177)
TOTAL NET REVENUES	60,388	593,408	2,482	(60,565)	595,713
TOTAL COST OF NET REVENUES		250,484	1,359	(177)	251,666
Provision for doubtful accounts		11,800	58		11,858
Selling, distribution and administrative	44,280	332,789	741	(60,388)	317,422
Amortization of intangible assets	229	432			661
TOTAL COSTS AND EXPENSES	44,509	595,505	2,158	(60,565)	581,607
OPERATING INCOME (LOSS)	15,879	(2,097)	324		14,106
Interest expense	33,045	472			33,517
Interest income and other	(15,730)	14,869	159		(702)
(LOSS) INCOME BEFORE TAXES	(1,436)	(17,438)	165		(18,709)
Income tax (benefit) expense	(7)	905			898
NET (LOSS) INCOME	(1,429)	(18,343)	165		(19,607)
Equity in income of subsidiaries, net of tax	(18,178)	165		18,013	
NET (LOSS) INCOME	$ (19,607)	$ (18,178)	$ 165	$ 18,013	$ (19,607)

Table of Contents

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

Three Months Ended March 31, 2013

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
OPERATING ACTIVITIES					
NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES	$ 12,391	$ 17,061	$ 115	$ (2,148)	$ 27,419
INVESTING ACTIVITIES					
Purchases of patient service equipment and property, equipment and improvements	(5,577)	(31,332)			(36,909)
Proceeds from sale of patient service equipment and other	16	10,991			11,007
NET CASH USED IN INVESTING ACTIVITIES	(5,561)	(20,341)			(25,902)
FINANCING ACTIVITIES					
Proceeds from ABL Facility	146,000				146,000
Payments on ABL Facility	(159,000)				(159,000)
Payments on other long-term debt		(74)			(74)
NET CASH USED IN FINANCING ACTIVITIES	(13,000)	(74)			(13,074)
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(6,170)	(3,354)	115	(2,148)	(11,557)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	23,457	3,354	269		27,080
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 17,287	$	$ 384	$ (2,148)	$ 15,523

Table of Contents

CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS

Three Months Ended March 31, 2012

(Unaudited)

	Issuer	Guarantor Subsidiaries	Non-Guarantor Subsidiaries	Consolidating Adjustments	Consolidated
			(in thousands)		
OPERATING ACTIVITIES					
NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES	$ (16,771)	$ 29,485	$ (71)	$ 5,213	$ 17,856
INVESTING ACTIVITIES					
Purchases of patient service equipment and property, equipment and improvements	(3,953)	(40,830)			(44,783)
Proceeds from sale of patient service equipment and other		11,525			11,525
Cash paid for acquisitions		(94)			(94)
NET CASH USED IN INVESTING ACTIVITIES	(3,953)	(29,399)			(33,352)
FINANCING ACTIVITIES					
Proceeds from ABL Facility	67,000				67,000
Payments on ABL Facility	(57,000)				(57,000)
Payments on other long-term debt		(86)			(86)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	10,000	(86)			9,914
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(10,724)		(71)	5,213	(5,582)
CASH AND CASH EQUIVALENTS AT BEGINNING OF PERIOD	43,552		475	(14,931)	29,096
CASH AND CASH EQUIVALENTS AT END OF PERIOD	$ 32,828	$	$ 404	$ (9,718)	$ 23,514

Table of Contents

NOTE 13 SUBSEQUENT EVENTS

Refinancing of Debt. On April 5, 2013, the Company entered into a senior secured credit agreement (the Credit Agreement), among Apria, as borrower, Sky Acquisition LLC, as parent, the other guarantors party thereto from time to time, Bank of America, N.A., as administrative agent, U.S. Bank National Association as collateral agent, certain other agents party thereto and a syndicate of financial institutions and institutional lenders. Bank of America, N.A., Goldman Sachs Bank USA, Barclays Bank PLC, Wells Fargo Securities LLC and Macquarie Capital (USA) Inc. acted as joint lead arrangers and joint bookrunners.

On April 5, 2013, the Company borrowed $900.0 million in aggregate principal amount of term loans under the Credit Agreement. At the Company s option the Company may borrow additional term loans under the Credit Agreement, subject to certain customary conditions, including consent of the lenders providing such additional term loans, in an amount not to exceed $175.0 million, plus the aggregate principal amount of voluntary prepayments of term loans on or prior to such time, plus additional amounts subject to compliance on a pro forma basis with certain financial ratio tests.

Borrowings under the Credit Agreement bear interest at a fluctuating rate per annum equal to, at the Company s option (i) a base rate equal to the highest of (a) the federal funds rate plus 1/2 of 1%, (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America, N.A. as its prime rate and (c) the one month LIBOR Rate plus 1.00% (provided that in no event shall such base rate with respect to the initial Term Loans be less than 2.25% per annum), in each case plus an applicable margin of 4.50% or (ii) a LIBOR Rate for the applicable interest period (provided that in no event shall such LIBOR rate with respect to the initial Term Loans be less than 1.25% per annum) plus an applicable margin of 5.50%.

The Credit Agreement will mature on April 5, 2020 and will amortize in equal quarterly installments in aggregate annual amounts equal to 1% of the original principal amount of term loans, with the balance payable on the final maturity date; *provided* that the Credit Agreement provides the right for individual lenders to agree to extend the maturity date of their outstanding term loans upon the Company s request and without the consent of any other lender, subject to customary terms and conditions.

All the Company s obligations under the Credit Agreement (i) are unconditionally guaranteed by the Company s parent and substantially all of its existing and future, direct and indirect, wholly-owned domestic restricted subsidiaries and (ii) are secured, subject to certain exceptions, by substantially all of the Company s assets and the assets of the guarantors.

The Credit Agreement includes a financial maintenance covenant that prohibits the Company s consolidated first priority net leverage ratio as of the last day of any test period of four consecutive fiscal quarters (commencing with the test period ending September 30, 2013) to exceed 5.50 to 1.00.

The Credit Agreement also includes customary negative covenants that, subject to significant exceptions, limit the Company s ability and the ability of the Company s parent and subsidiaries to, among other things: incur liens; make investments or loans; incur, assume or permit to exist additional indebtedness or guarantees; and pay dividends, make payments or redeem or repurchase capital stock. Under the terms of the Credit Agreement, outstanding loans under the Credit Agreement may be accelerated if more than $75.0 million of the Series A-2 Notes remain outstanding on or after September 2, 2014.

The Company used the proceeds from the borrowings under the Credit Agreement to: (i) deposit the redemption price for all of the Company s outstanding 11.25% Senior Secured Notes due 2014 (Series A-1) (the Series A-1 Notes) with the trustee under the indenture governing the Notes (as defined below); (ii) deposit the redemption price for an aggregate principal amount of $160.0 million of the Company s outstanding 12.375% Senior Secured Notes due 2014 (Series A-2) (the Series A-2 Notes and, together with the Series A-1 Notes, the Notes) with the trustee under the indenture governing the Series A-1 Notes and Series A-2 Notes and (iii) pay fees and expenses associated with the entering into the Credit Agreement and the redemption of the Notes.

On April 5, 2013, the Company provided a notice of redemption for all of its outstanding Series A-1 Notes and an aggregate principal amount of $160.0 million of its outstanding Series A-2 Notes. Each of the Series A-1 Notes and Series A-2 Notes will be redeemed on May 6, 2013 (the Redemption Date). The Series A-1 Notes will be redeemed at a redemption price of 102.813% of the aggregate principal amount thereof and the Series A-2 Notes will be redeemed at a redemption price of 103.094% of the aggregate principal amount being redeemed, in each case, plus accrued and unpaid interest to, but not including the Redemption Date. In addition, the Company effected a satisfaction and discharge of the Company s obligations with respect to the Series A-1 Notes under the indenture governing the Notes.

29

Table of Contents

ITEM 2. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

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

Overview. We have four core service lines: home respiratory therapy, home medical equipment, home infusion therapy, including total parenteral nutrition (TPN) services, and enteral nutrition services. In these core service lines, we offer a variety of patient care management programs, including clinical and administrative support services, products and supplies, most of which are prescribed by a physician as part of a care plan. We provide these services to patients through approximately 520 locations throughout the United States. We have two reportable operating segments:

home respiratory therapy and home medical equipment; and

home infusion therapy.

Recent Events

Refinancing of Debt. On April 5, 2013, we entered into a senior secured credit agreement (the Credit Agreement), among Apria, as borrower, Sky Acquisition LLC, as parent, the other guarantors party thereto from time to time, Bank of America, N.A., as administrative agent, U.S. Bank National Association as collateral agent, certain other agents party thereto and a syndicate of financial institutions and institutional lenders. Bank of America, N.A., Goldman Sachs Bank USA, Barclays Bank PLC, Wells Fargo Securities LLC and Macquarie Capital (USA) Inc. acted as joint lead arrangers and joint bookrunners.

On April 5, 2013, we borrowed $900.0 million in aggregate principal amount of term loans under the Credit Agreement. At our option we may borrow additional term loans under the Credit Agreement, subject to certain customary conditions, including consent of the lenders providing such additional term loans, in an amount not to exceed $175.0 million, plus the aggregate principal amount of voluntary prepayments of term loans on or prior to such time, plus additional amounts subject to compliance on a pro forma basis with certain financial ratio tests.

Borrowings under the Credit Agreement bear interest at a fluctuating rate per annum equal to, at our option (i) a base rate equal to the highest of (a) the federal funds rate plus 1/2 of 1%, (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America, N.A. as its prime rate and (c) the one month LIBOR Rate plus 1.00% (provided that in no event shall such base rate with respect to the initial Term Loans be less than 2.25% per annum), in each case plus an applicable margin of 4.50% or (ii) a LIBOR Rate for the applicable interest period (provided that in no event shall such LIBOR rate with respect to the initial Term Loans be less than 1.25% per annum) plus an applicable margin of 5.50%.

The Credit Agreement will mature on April 5, 2020 and will amortize in equal quarterly installments in aggregate annual amounts equal to 1% of the original principal amount of term loans, with the balance payable on the final maturity date; *provided* that the Credit Agreement provides the right for individual lenders to agree to extend the maturity date of their outstanding term loans upon our request and without the consent of any other lender, subject to customary terms and conditions.

All our obligations under the Credit Agreement (i) are unconditionally guaranteed by our parent and substantially all of our existing and future, direct and indirect, wholly-owned domestic restricted subsidiaries and (ii) are secured, subject to certain exceptions, by substantially all of our assets and the assets of the guarantors.

The Credit Agreement includes a financial maintenance covenant that prohibits our consolidated first priority net leverage ratio as of the last day of any test period of four consecutive fiscal quarters (commencing with the test period ending September 30, 2013) to exceed 5.50 to 1.00.

30

Table of Contents

The Credit Agreement also includes customary negative covenants that, subject to significant exceptions, limit our ability and the ability of our parent and subsidiaries to, among other things: incur liens; make investments or loans; incur, assume or permit to exist additional indebtedness or guarantees; and pay dividends, make payments or redeem or repurchase capital stock.

We used the proceeds from the borrowings under the Credit Agreement to: (i) deposit the redemption price for all of our outstanding 11.25% Senior Secured Notes due 2014 (Series A-1) (the Series A-1 Notes) with the trustee under the indenture governing the Notes (as defined below); (ii) deposit the redemption price for an aggregate principal amount of $160.0 million of our outstanding 12.375% Senior Secured Notes due 2014 (Series A-2) (the Series A-2 Notes and, together with the Series A-1 Notes, the Notes) with the trustee under the indenture governing the Series A-1 Notes and Series A-2 Notes and (iii) pay fees and expenses associated with the entering into the Credit Agreement and the redemption of the Notes.

On April 5, 2013, we provided a notice of redemption for all of its outstanding Series A-1 Notes and an aggregate principal amount of $160.0 million of its outstanding Series A-2 Notes. Each of the Series A-1 Notes and Series A-2 Notes will be redeemed on May 6, 2013 (the Redemption Date). The Series A-1 Notes will be redeemed at a redemption price of 102.813% of the aggregate principal amount thereof and the Series A-2 Notes will be redeemed at a redemption price of 103.094% of the aggregate principal amount being redeemed, in each case, plus accrued and unpaid interest to, but not including the Redemption Date. In addition, we effected a satisfaction and discharge of our obligations with respect to the Series A-1 Notes under the indenture governing the Notes.

Strategy

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

Grow profitable revenue and market share. We are focused on growing profitable revenues and increasing market share in our core home infusion therapy and home respiratory therapy service lines. We have undertaken a series of steps towards this end. Since our acquisition of Coram in December 2007, we have grown our revenue and patient census in the home infusion therapy segment and expanded our platform for further cross-selling opportunities. Our acquisition of Praxair s homecare business in the United States in March 2011 expanded our geographic footprint and market share in several key markets of the country. Since early 2010, we have expanded our home respiratory therapy and home medical equipment sales force by 20%, of which 7% relates to the acquisition of Praxair assets. During the same time period, the specialty infusion sales force has grown by 33% and become further stratified with dedicated sales resources allocated to fast-growing therapeutic service lines. This expansion in both business units has allowed us to more efficiently cover each market served by promoting our products and services to physicians, clinical specialists, hospital discharge planners and managed care organizations. On an ongoing basis, we continually evaluate the size of our sales force and the products/services we offer to the market within the context of changing market conditions, the competitive landscape, pricing, opportunities and threats. Additionally, this may include exiting certain products, markets, payors, and hospital agreements or reorganizing certain operations of our company.

Continue to participate in the managed care market and pursue opportunities created by healthcare reform. We participate in the managed care market as a long-term strategic customer group because we believe that our scale, expertise, nationwide presence and array of home healthcare products and services enable us to sign preferred provider agreements and participating Health Maintenance Organization (HMO) agreements with managed care organizations. Managed care represented approximately 71% of our total net revenues for the three months ended March 31, 2013. Healthcare reform may create new models of care, such as Accountable Care Organizations and state insurance exchanges. Our size and scope of services may give us a competitive advantage in serving these new markets.

Leverage our national distribution infrastructure. With approximately 520 locations and a robust platform supporting shared national services, we believe that we can efficiently add products, services and patients to our systems to grow our revenues and leverage our cost structure. For example, we have successfully leveraged this distribution platform across a number of product and service offerings, including a continuous positive airway pressure (CPAP)/ bi-level supply replenishment program, enteral nutrition and negative pressure wound therapy (NPWT) services, and we are using our nursing capacity to provide infusion services through our growing network of ambulatory infusion suites. We seek to achieve margin improvements through operational initiatives focused on the continual reduction of costs and delivery of incremental efficiencies. At the same time, we believe that it is essential to

consistently deliver superior customer service in order to increase referrals and retain existing patients. Performance improvement initiatives are underway in all aspects of our operations including customer service, patient and referral satisfaction, logistics, supply chain, clinical services and billing/collections. We believe that by being responsive to the needs of our patients and payors we can provide ourselves with opportunities to take market share from our competitors.

Table of Contents

Continue to lead the industry in accreditation. The Medicare Improvement for Patients Act of 2008 (MIPPA) made accreditation mandatory for Medicare providers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), effective October 1, 2009, per Centers for Medicare and Medicaid Services (CMS) regulation. We were the first durable medical equipment provider to seek and obtain voluntary accreditation from The Joint Commission (the Commission). In June 2010, we completed a nationwide independent triennial accreditation renewal process conducted by The Joint Commission and the Commission renewed our accreditation for another three years. The Company is currently undergoing another triennial survey cycle and expects to renew its accreditation for another three years by the Summer of 2013.The Commission accreditation encompasses our full complement of services including home health, home medical equipment, clinical respiratory, ambulatory infusion services, pharmacy dispensing, and clinical consultant pharmacist services. We have more than 24 years of continuous accreditation by the Commission longer than any other homecare provider.

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

***Critical Accounting Policies*.** We consider the accounting policies that govern revenue recognition and the determination of the net realizable value of accounts receivable to be the most critical in relation to our consolidated financial statements. These policies require the most complex and subjective judgments of management. Additionally, the accounting policies related to goodwill, long-lived assets, share-based compensation and income taxes require significant judgment. These policies are presented in detail in the *Management s Discussion and Analysis of Financial Condition and Results of Operations* section in our Annual Report for the year ended December 31, 2012.

Government Regulation

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

Medicare and Medicaid Revenues. In the three months ended March 31, 2013, approximately 29% of our net revenues were reimbursed by the Medicare and state Medicaid programs. No other third-party payor represented more than 9% of our total net revenues for the three months ended March 31, 2013. The majority of our revenues are derived from rental income on equipment rented and related services provided to patients, sales of equipment, supplies and pharmaceuticals and other items we sell to patients for patient care under fee-for-service arrangements. Revenues derived from capitation arrangements represented 7% of total net revenues for the three months ended March 31, 2013, respectively.

Medicare Reimbursement. There are a number of legislative and regulatory initiatives in Congress and at CMS that affect or may affect Medicare reimbursement policies for products and services we provide. Specifically, a number of important legislative changes that affect our business were included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003

Table of Contents

(MMA); the Deficit Reduction Act of 2005 (DRA); MIPPA, which became law in 2008, the comprehensive healthcare reform law signed in March 2010 (the Reform Package), the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012. These Acts and their implementing regulations and guidelines contain numerous provisions that are significant to us and continue to have an impact on our operations today.

Budget Control Act of 2011. In August 2011, the Budget Control Act of 2011 was signed into law. The Budget Control Act of 2011 authorized increases in the United States debt limit of at least $2.1 trillion, established caps on funding appropriations estimated to reduce federal spending by $917 billion over the next ten years, and created the Joint Select Committee on Deficit Reduction (Joint Committee), a bipartisan Congressional committee instructed to develop legislation to reduce the federal deficit by at least another $1.5 trillion over the ten-year period of fiscal years 2012 2021. Because Congress and the President failed to enact legislation reducing the deficit by at least $1.2 trillion over the ten-year period of fiscal years 2012 2021 by the January 15, 2012 deadline, automatic spending reductions in fiscal years 2013 2021 through sequestration (the required cancellation of budgetary resources), has been triggered. Under sequestration, certain federal programs are protected, including Medicaid. However, effective April 1, 2013, sequestration has caused payments to Medicare providers and suppliers to be reduced by 2%. This reduction applies to both competitively bid and non-competitively bid markets and products. It is unclear how long these reductions will be in effect. These reductions, along with any further reductions in provider and supplier reimbursement rates under federal healthcare programs, could have a material adverse effect on our financial condition and results of operations.

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

Although CMS administered a bid process in 2007 and launched the original Round 1 program in mid-2008, shortly thereafter, MIPPA was enacted. This delayed the DMEPOS competitive bidding program by requiring that Round 1 competition commence in 2009 and required a number of program reforms prior to CMS re-launching the program. Changes mandated by MIPPA included requirements for the government to administer the program more transparently, exemption of certain DMEPOS products from the program and a new implementation schedule.

Under MIPPA, the initial CBAs and product categories subject to rebidding in the Round 1 Rebid were very similar to those of Round 1. However, MIPPA excluded Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories as a competitive bidding product category in Round 1 and permanently excluded Group 3 Complex Rehabilitative Power Wheelchairs and Related Accessories as a competitive bidding product category.

We received contract offers for a substantial majority of the Round 1 Rebid bids we submitted. The rates took effect on January 1, 2011 for the Round 1 Rebid markets and remain in place through the end of the three-year contract period, December 31, 2013. CMS reports that the average price reduction for all products in all Round 1 Rebid CBAs was 32%. After the price reduction and volume growth/reduction experienced in the Round 1 Rebid markets is accounted for, an estimated $16.6 million of net revenue was subject to bidding in the calendar year ending December 31, 2012.

In April 2012, CMS announced the product categories to be included in the recompete of the Round 1 Rebid contracts and an associated schedule. The Round 1 Rebid Recompete includes additional products and CMS has elected to group products in an all-new way, such as a Respiratory Equipment category which includes oxygen therapy, sleep therapy and nebulizers, and a General Home Equipment category which includes a variety of home medical equipment, accessories and supplies. CMS concluded the bid submission process in the fourth quarter of 2012. New rates for the Round 1 Rebid Recompete are scheduled to be announced in Spring 2013 and take effect on January 1, 2014. We estimate that once the additional products which are included in the Round 1 Recompete program phase (which takes effect in January 2014) are accounted for, the estimated annual total net revenues associated with items subject to competitive bidding in the Round 1 markets will be approximately $20.1 million for the 2012 calendar year, or 0.8% of our annual total net revenues.

Notwithstanding the changes implemented by MIPPA, competitive bidding imposes a significant risk to DMEPOS suppliers under the rules governing the program. If a DMEPOS supplier operating in a CBA is not awarded a contract for that CBA, the supplier generally will not be able to bill and be reimbursed by Medicare for DMEPOS items supplied in that CBA for the time period covered by the competitive bidding program unless the supplier meets certain exceptions or acquires a winning bidder. Because the applicable statutes mandate financial savings from the competitive bidding program, a winning contract supplier will receive lower Medicare payment rates under competitive bidding than the otherwise applicable DMEPOS fee schedule rates. As competitive bidding is phased in across the country under the revised MIPPA and Reform Package implementation schedule, we will experience a reduction in reimbursement, as will most if not all other DMEPOS suppliers participating in the impacted areas. In addition, there is an increasing

33

Table of Contents

risk that the competitive bidding prices will become a benchmark for reimbursement from other payors, as evidenced by the Administration s 2013 and 2014 fiscal budget proposals which would limit state Medicaid reimbursement levels for certain durable medical equipment services and products to Medicare reimbursement rates for the same products and services in the same state. Neither MIPPA nor the Reform Package prevents CMS from adjusting prices for DMEPOS items in non-bid areas in 2016; however, before using its authority to adjust prices in non-bid areas, MIPPA requires that CMS issue a regulation that specifies the methodology to be used and consider how prices through competitive bidding compare to costs for those items and services in the non-bid areas.

The Reform Package also included changes to the Medicare DMEPOS competitive bidding program. Significantly, Round 2 of the competitive bidding program was expanded from 70 to 91 of the largest MSAs. Round 2 includes the majority of the same product categories as Round 1, but CMS expanded the program by (i) combining standard power wheelchairs and manual wheelchairs into a single new product category, (ii) including Negative Pressure Wound Therapy as a category in all Round 2 markets and (iii) including the Support Surfaces (Group 2 mattresses and overlays) category in all Round 2 markets. The bid process for Round 2 ended on March 30, 2012. CMS announced the Single Payment Amounts (SPAs) on January 30, 2013, at which time the agency began the contract offer process. The contracting process ran through March 2013 and on April 9, 2013 CMS announced the Round 2 contract suppliers and issued formal three-year contracts to the same. The new Round 2 rates and guidelines currently are scheduled to take effect on July 1, 2013. We estimate that approximately $122 million of our net revenues for the fiscal year ending December 31, 2012 is subject to competitive bidding in this round. CMS reported that the average payment reduction for Round 2 will be 45%. After applying the actual SPAs for each impacted CBA to Apria s actual 2012 revenue for the product categories included in the bidding program, the Company estimates that the Round 2 revenue reduction is $57 million before any changes in volume are accounted for as a result of the contract offers received and accepted.

The Reform Package also gives the Secretary of Health and Human Services additional authority to apply competitive bid pricing to non-bid areas via a rulemaking process and that could occur by 2016. In addition, efforts to repeal the competitive bidding program altogether or mandate significant program changes continue. In March 2011, the Fairness in Medicare Bidding Act of 2011 (FIMBA) was introduced into the U.S. House of Representatives and referred to the House Subcommittee on Health. FIMBA would have repealed the program without specifying a reduction in the industry s current reimbursement levels. Other efforts are underway by independent economists who seek to alter certain critical aspects of the program. Specifically, those efforts are designed to change the way in which CMS conducts the auction process itself, establishes the single payment rates, determines supplier capacity needed and related aspects which, if adopted by CMS in their entirety or in part, would change how the program would be administered. In September 2012, a bill titled Medicare DMEPOS Market Pricing Program Act of 2012 was introduced in Congress and referred to the Committee on Energy and Commerce and the Committee on Ways and Means. The bill would repeal the current DMEPOS competitive bidding program as designed and replace it with a modified auction program. In January 2013, a bill titled Small Supplier Fairness in Bidding Competition Act of 2013 was introduced to repeal the program and was referred to the House Committee on Small Business. We cannot predict whether these or other efforts to repeal or amend the program will be successful, or their potential impact on us.

We believe that our geographic coverage, clinical marketing programs and purchasing strength provide competitive advantages to maintain and enhance market share under Medicare competitive bidding. In February 2013 we were offered Round 2 competitive bidding contracts for a substantial majority of the CBAs and products for which we submitted bids. However, there is no guarantee that we will garner additional market share as a result of these contracts. Both the Round 1 Rebid Recompete and Round 2 of the DMEPOS competitive bidding program include products which may require the Company to subcontract certain services or products to be performed on its behalf, and there is no guarantee that CMS will either approve such subcontracting arrangements or that the subcontractor will perform its contractual obligations to us. Certain aspects of the program s oversight and administration remain unclear in CMS written regulations that have been promulgated and therefore individual negotiations may be required between the Company, CMS and/or its contractors. The outcome of such negotiations cannot be predicted or assured. Under the current competitive bidding regulations, in the CBAs, and for the products, for which we do not have competitive bidding contracts, we will generally not be allowed to supply Medicare beneficiaries in the CBA with products subject to competitive bidding for the contract term of the program, unless we elect to continue to service existing patients under the grandfathering provision of the program s final rule for certain products. Because of our combination of both managed care and traditional business, we believe we can nevertheless maintain a favorable overall market position in a particular CBA even if we are not a contract supplier for certain products.

Medicare Fee Schedule for DMEPOS and Consumer Price Index-Urban (CPI-U) Adjustments. In addition to the adoption of the DMEPOS competitive bidding program, the MMA implemented a five-year freeze on annual Consumer Price Index (CPI) payment increases for most durable medical equipment from 2004 to 2008. In MIPPA, in order to offset the cost of delaying the implementation of the DMEPOS competitive bidding program, Congress approved a nationwide average payment reduction of 9.5% in the DMEPOS fee schedule payments for those product categories included in Round 1, effective January 1, 2009. Product

Table of Contents

categories subject to competitive bidding but furnished in non-competitive bid areas were eligible to receive mandatory annual CPI-U updates beginning in 2010. Competitively bid items and services in metropolitan areas with contracts in place are not eligible to receive a CPI-U payment update during a contract period, which, except for the mail order diabetes contract, is currently a three-year period.

The DMEPOS items and services that were not in a product category subject to competitive bidding in Round 1 received a 5% CPI-U payment update in 2009. For 2010, the CPI-U was -1.4%. However, annual DMEPOS payment updates were not permitted to be negative according to statute. Therefore, the CPI update in 2010 was 0%. The Reform Package makes changes to Medicare DMEPOS fee schedule payments for 2011 and subsequent years. The CPI-U payment update is now adjusted annually by a new multi-factor productivity adjustment measurement which may result in negative DMEPOS payment updates. While CPI-U for 2011 was +1.1%, the multi-factor productivity adjustment was -1.2%, so the net result was a 0.1% decrease in DMEPOS fee schedule payments in 2011 for items and services not included in an area subject to competitive bidding. The CPI-U for 2012 was +3.6%, but the multi-factor productivity adjustment remained -1.2%, so the net result was a 2.4% increase in DMEPOS fee schedule payments in 2012 for items and services not included in an area subject to competitive bidding. For 2013, the CPI-U is +1.7%, but the adjustment is -0.9%, so the net result is a 0.8% increase in DMEPOS fee schedule payments in 2013 for the same items and services as described above.

The Administration s 2014 fiscal budget proposal would change the way the government calculates the annual cost-of-living adjustments for government benefit programs, among other things. As compared to the current CPI method, the switch in the inflation formula would cut spending on government benefit programs by $130 billion over 10 years. At this time, it is unclear how this change, if implemented, would impact annual DMEPOS payment updates. It is possible that such a change, if implemented, could have an adverse impact on our business, financial condition, results of operation, cash flow, capital resources and liquidity.

Capped Rentals, Oxygen Equipment and PAP Patient Compliance. Under the DRA, ownership of certain durable medical equipment categorized by CMS in the capped rental category (e.g., hospital beds, wheelchairs, nebulizers, patient lifts and PAP devices) automatically transfers to the Medicare beneficiary at the end of a maximum rental period. As of January 1, 2006, the maximum rental period for this category became 13 months. DRA regulations published subsequently established new payment classes for oxygen equipment, including transfilling and portable equipment, new monthly rental reimbursement rates, and new reimbursement rates for the delivery of oxygen contents.

With respect to oxygen equipment, Medicare reimbursement for oxygen equipment is limited to a maximum of 36 months, after which time the equipment continues to be owned by the home oxygen provider for as long as the patient s medical need exists and the provider continues to be responsible for his/her care. Limited reimbursement is available to providers from months 37 through 60, depending on the oxygen modality and patient s needs. CMS does not reimburse suppliers for oxygen tubing, cannulas and supplies patients may need between the 37th and 60th months of oxygen therapy and requires that the initial supplier of oxygen therapy make arrangements with another supplier if a patient relocates temporarily or permanently outside of the initial supplier s service area. In addition, CMS did not establish any reimbursement rates for non-routine services patients may require after the 36-month rental period. In fact, implementing regulations impose other repair and replacement obligations on suppliers with respect to equipment that does not last the useful lifetime of the equipment, which CMS has generally defined as being five years. The existing implementing regulations to the DRA and MIPPA provisions limit supplier replacement of oxygen equipment during the rental period, and require suppliers to replace equipment that does not last the useful lifetime of the equipment. After the five year useful life is reached, the patient may request replacement equipment and, if he/she can be requalified for the Medicare benefit, a new maximum 36-month rental period would begin. The supplier may not arbitrarily issue new equipment.

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

In a proposed rule issued in June 2010, CMS proposed to change the threshold rental month from which the original oxygen supplier would continue to be responsible for serving a patient, regardless of his/her move outside of the supplier s service area, from the 36th to the 18th month. The agency sought public comments, and in a final rule published in November 2010, the agency indicated that it would not change its current policy but would continue to study the issue. We cannot speculate on any future changes CMS may

Table of Contents

make to its repair, maintenance and service, supply or other fee schedules related to oxygen. We may or may not continue to provide repair and maintenance service on oxygen equipment that has met the cap. We routinely evaluate the impact of the changes caused by all applicable legislation and regulations and adjust our operating policies accordingly.

In recent years, there have been legislative and executive branch efforts to further reduce the maximum rental period for oxygen therapy, equipment and related services. However, President Obama s 2012, 2013 and 2014 budget proposals did not include a reduction in the oxygen rental period; neither did the Reform Package. Nonetheless, President Obama s 2013 and 2014 fiscal budget proposals would limit the state Medicaid reimbursement levels for certain durable medical equipment services and products, including oxygen therapy, to Medicare reimbursement rates for the same products and services in the same state, including those impacted by the Medicare DMEPOS competitive bidding program. It is premature to know whether this or future budgets or proposals will contain such a provision or any other provisions based on these or future studies released by one or more government agencies.

CMS and the durable medical equipment Medicare administrative contractors (DME MACs) also have issued coverage determinations for positive airway pressure (PAP) devices, including CPAP and bi-level devices. Among other changes, the Medicare DME MAC local coverage determinations (LCDs) require additional documentation of clinical benefit of the PAP devices for continued coverage of the device beyond the first three months of therapy. Specifically, for PAP, documentation of clinical benefit must be demonstrated by: (1) a face-to-face clinical re-evaluation by the treating physician (between the 31st and 90th day) with documentation that symptoms of obstructive sleep apnea are improved; and (2) objective evidence of adherence to use of the PAP device, reviewed by the treating physician. The LCDs define adherence to therapy as the use of the PAP device greater than or equal to four (4) hours per night on 70% of nights during a consecutive 30-day period anytime during the first three months of initial usage. If the clinical benefit requirements are not met, then continued coverage of the PAP device and related accessories are denied by Medicare as not medically necessary. We believe these requirements effectively require suppliers to supply PAP devices that monitor patient compliance and record hours of use, which adds to our expense structure without a corresponding increase in payments from Medicare. We adjusted our operational model, patient care and payment policies to comply with these Medicare coverage requirements when they were implemented. These requirements apply to Medicare Part B fee-for-service (FFS) patients, not to those patients enrolled in Medicare Advantage or commercial health plans, and Medicare Part B FFS represents a smaller portion of the overall PAP patient market. However, some commercial and Medicare Advantage payors have implemented the same, similar or, at times, more arduous rules as those adopted by Medicare. Despite our continuous and intensive efforts to educate patients about the importance of complying with their physician-prescribed therapy, some of our patients do not meet the threshold for compliance. We continue to educate patients and referral sources concerning the importance of compliance with the patient s prescribed therapy and the government s need for documentation pertaining to initial and ongoing medical necessity. However, these and similar LCDs and trends are likely to continue to significantly impact the PAP industry.

Reimbursement for Inhalation and Infusion Therapy Drugs. As a result of the MMA, Medicare Part B reimbursement for most drugs, including inhalation drugs, is based upon the manufacturer-reported average sales price (ASP) (subject to adjustment each quarter), plus 6%. In 2011, CMS published regulations adopting a price substitution policy whereby reimbursement would be limited to 103% of the Average Manufacturer Price (AMP) under certain circumstances, including when ASP exceeds AMP by 5% for either two consecutive quarters or three of the previous four quarters. However, according to a December 2012 OIG report, CMS has yet to implement this policy. CMS publishes the ASP plus 6% payment levels in the month that precedes the first day of each quarter, and we have no way of knowing if the quarterly ASPs will increase or decrease since manufacturers report applicable ASP information directly to CMS. Since 2006, dispensing fees have remained at $57.00 for a 30-day supply for a new patient, $33.00 for each 30-day supply thereafter, and $66.00 for each 90-day supply.

The Medicare reimbursement methodology for non-compounded, infused drugs administered through durable medical equipment, such as infusion pumps, was not affected by this MMA change. It remains based upon either 95% of the October 1, 2003 Average Wholesale Price (AWP) or, for those drugs whose AWPs were not published in the applicable 2003 compendia, at 95% of the first published AWP. However, in a first quarter 2013 written response to an OIG report concerning Part B infusion drug reimbursement, CMS expressed an interest in including these drugs / therapies in future phases of the DMEPOS competitive bidding program. Such inclusion could occur no earlier than the Recompete of Round 2, which does not take effect until July 2016. Since CMS has not announced any definitive plans, at this time we cannot predict whether the Medicare reimbursement methodology for these drugs will in fact change, nor can we predict when these changes would occur.

Late in the last decade, there were other changes to the reimbursement methodology for certain inhalation drugs. When CMS changed its reimbursement methodology for calculating the ASP, CMS reduced its reimbursement to providers of Xopenex and albuterol. We implemented strategies intended to partially mitigate these negative impacts in our operations, including the discontinuation of the inhalation drug Xopenex from our inhalation pharmacies drug formulary and other formulary changes.

Table of Contents

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

Due to ongoing Part D and Part B coverage and payment issues associated with home infusion therapy, the industry is continuing to work with CMS, the Center for Medicare and Medicaid Innovation (CMMI) and Congress to rectify the Medicare coverage and payment limitations that restrict Medicare beneficiary and referral source access to quality home infusion therapy services. Bills were introduced in the 110th, 111th and 112th Congresses to consolidate home infusion therapy coverage under Part B. The Medicare Home Infusion Therapy Coverage Act would provide for Medicare infusion benefit coverage in a more comprehensive manner that is analogous to how the therapy is covered by the managed care sector, including Medicare Advantage plans. Industry representatives continue to present the cost-saving and patient care advantages of home infusion therapy to CMS, members of Congress and the Obama Administration in an effort to, at a minimum, include a formal demonstration project in either CMS s or the CMMI s work plan or future legislation. In addition to a June 2010 report issued by the GAO, entitled Home Infusion Therapy: Differences Between Medicare and Private Insurers Coverage, testimony before the Senate Finance Committee in fall 2009 acknowledged the current gap in coverage and potential benefits of home infusion therapy to the Medicare program and beneficiaries. In June 2012, the Medicare Payment Advisory Commission (MedPAC), in its annual report to Congress, also acknowledged certain coverage gaps associated with home infusion therapy and concluded that additional research is warranted. During the same month, the House Ways and Means Subcommittee on Health held a hearing that focused on MedPAC s report. Groups such as the National Home Infusion Association, in comments to the Subcommittee, criticized MedPAC s report and recommended that there be a demonstration project to examine the benefit for home infusion therapy. Recently, Congress passed and President Obama signed into law legislation requiring a demonstration project providing Medicare coverage for items and services related to the in-home administration of intravenous immune globulin (IVIG). The industry is continuing to collect cost-benefit data that will provide an objective basis for Congress, CMS and/or the CMMI to make a decision to fund other such demonstration projects. At this time, we cannot predict whether additional legislation will be passed or whether CMS and/or the CMMI will include other demonstration projects in a future work plan.

In February 2013, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) released a report entitled, Part B Payments for Drugs Infused Through Durable Medical Equipment . The report compared the ASP of each DME infused drug to its AWP-based Medicare payment amount for every year between 2005 and 2011. The report found that, overall, Medicare payment amounts for DME infusion drugs exceeded ASPs by 54 to 122 percent annually. The report also found that Medicare spending on DME infusion drugs would have been reduced by 44% ($344 million) between 2005 and 2011, had payment been based on ASPs. However, the report found that for as many as one third of DME infusion drugs in each year, the payment amounts were below their ASPs, meaning that Medicare may be underpaying suppliers for those drugs. In the report, the OIG offered the following recommendations to CMS: (1) seek a legislative change requiring DME infusion drugs to be paid using the ASP methodology or (2) include DME infusion drugs in the next round of the DMEPOS competitive bidding program. CMS stated in its response to the OIG report that it is interested in including DME infusion drugs in a future round of the competitive bidding program but has not publicly commented on when this might occur. In addition, in order to preserve beneficiary access, and in the absence of wholesale reform of the Medicare home infusion therapy benefit, the government s adoption of the ASP methodology for infusion drugs would require an offset by establishing a reasonable dispensing fee to cover the extensive non-drug cost of serving beneficiaries, not unlike what CMS implemented for Part B inhalation therapies in 2003. Due to the complexities of the issue and the current competitive bidding timelines, at this time we cannot predict whether the Medicare reimbursement methodology for DME infusion drugs will change or, if so, when it will change.

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

CMS also requires that all durable medical equipment providers who bill the Medicare program maintain a surety bond of $50,000 per National Provider Identifier (NPI) number which Medicare has approved for billing privileges. We obtained the required surety bonds for all of our applicable locations before the October 2009 deadline and, more recently, for acquired companies. In addition, the NSC prescribes an elevated bond amount of $50,000 per occurrence of an adverse legal action within the 10 years

Table of Contents

preceding enrollment, reenrollment or revalidation. The rule is designed to ensure that Medicare can recover any erroneous payment amounts or civil money penalties up to $50,000 that result from fraudulent or abusive supplier billing practices.

In March 2013, the HHS OIG released a report entitled, Surety Bonds Remain an Underutilized Tool to Protect Medicare from Supplier Overpayments . In the report, the OIG found that CMS did not have accurate surety bond information for all suppliers. Additionally, the OIG found that CMS has yet to recover millions of dollars in supplier debt resulting from overpayments. In its response to the OIG report, CMS stated that it will make appropriate updates and improvements in conjunction with the OIG s recommendations. The Company believes its surety bonds are complete and accurate, but despite its best efforts, the Company cannot predict what follow-up activities CMS may undertake or new requirements it may implement in the future, or their impact on the Company.

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

In February 2011, CMS released a final rule implementing certain provisions of the Reform Package intended to prevent fraud, waste and abuse. This final rule includes new requirements regarding enrollment screening, enrollment application fees, payment suspension, temporary moratoria on enrollment and supplier termination. Significantly, as part of the final rule, CMS classified providers and suppliers as limited, moderate and high risk according to their risk of fraud, waste and abuse. Currently enrolled DMEPOS suppliers are classified in the moderate risk category while newly enrolled DMEPOS suppliers are classified in the high risk category. As such, DMEPOS suppliers will be under greater scrutiny relative to many other healthcare providers and suppliers. In October 2011 and more recently in March 2013, Senate representatives of key committees with jurisdiction over Medicare/Medicaid sent letters to U.S. Secretary of Health and Human Services Kathleen Sebelius, asking for an explanation as to why CMS has not yet imposed temporary moratoria on the enrollment of new providers and suppliers where there is a high risk for fraud. Additionally, CMS is implementing a provider and supplier enrollment screening system that automates its pre-enrollment risk assessment and screening processes. Recently, CMS announced that if Medicare claims are submitted with dates of service on or after May 1, 2013, if a referring physician/supplier is not registered in this system, submitted claims will be denied. According to CMS about 1% of physicians nationwide are not registered. We have undertaken extensive efforts to ensure that our referral sources are registered with the system, but a small percentage remain unregistered. We work cooperatively with CMS and its contractors in response to these initiatives to prevent fraud, waste and abuse but cannot predict whether CMS s various program integrity efforts will negatively impact our operations.

In August 2010, CMS released a final rule imposing more stringent standards for DMEPOS suppliers, which introduced several new enrollment standards and expanded some existing standards and participation requirements, all of which DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program. These standards became effective in September 2010. In March 2012, CMS issued a final rule revising four of the 30 Medicare supplier standards that apply to our business. The final rule clarified regulations concerning direct solicitation of Medicare beneficiaries, addressed the use of licensed subcontractors to perform certain services on a supplier s behalf and modified certain state licensure exceptions. The Company s policies and procedures comply with the revised standards.

Following the implementation of a three-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program, Congress required HHS to establish the RAC initiative as a permanent, nationwide program. Prior to initiating any audits, RACs are required to obtain CMS s pre-approval of the issue that will be subject to audit, and then post the approved audit issue on their websites. All RACs have now posted CMS-approved audit issues on their websites. The currently posted approved audit issues include those which apply to durable medical equipment suppliers. States have also implemented similar state Medicaid audit programs, often known as Medicaid Integrity Contractors (MICs). In addition, the Reform Package requires states to establish contracts with RACs to identify underpayments and overpayments and to recoup overpayments made for services provided under state Medicaid programs. Absent an exception, states were required to implement their RAC programs by January 1, 2012. We cannot at this time quantify any negative impact that the expansion of the RAC program or other similar programs may have on us.

Table of Contents

Another group of auditors is the Zone Program Integrity Contractors (ZPICs), who are responsible for ensuring the integrity of all Medicare-related claims. The ZPICs assumed the responsibilities previously held by Medicare s Program Safeguard Contractors (PSCs). Industry-wide, ZPIC audit activity has increased significantly since 2010 and is expected to continue to increase for the foreseeable future due to increased federal funding. The industry trade associations and certain Congressional committees of jurisdiction continue to advocate for more standardized and rational audit procedures, contractor transparency and consistency surrounding all government audit activity directed toward the DMEPOS industry and other healthcare segments.

CMS also has implemented the Comprehensive Error Rate Testing (CERT) program to measure the rate of improper payments in the Medicare FFS program. During each annual reporting period, CERT contractors randomly select a sample of claims, stratified by claim type, submitted to Carriers, MACs, DME MACs and Fiscal Intermediaries. CERT contractors then request documentation from the provider or supplier that submitted each of the claims. Based on the claims review conducted by the CERT contractors and on an annual basis, the CERT contractors calculate an improper payment rate that is considered to be reflective of all paid claims in the Medicare FFS program during the year. The 2011 Medicare FFS improper payment rate was 8.6%, representing nearly $29 billion in allegedly improper payments. The projected improper payment amount for DMEPOS during the 2011 period was approximately 68%, with approximately 91% representing not fraud but technical errors due to insufficient documentation to meet the new and changing auditing standards.

The American Taxpayer Relief Act of 2012 extended the recoupment period for overpayments from three years to five years. This further expands the scope of audit activity, which is already paper-intensive, administratively burdensome and redundant. Appeals are protracted over many months. We cannot predict the impact of all governmental auditing activities and ever-changing rules issued by the same on our business, but it may be material.

Other Issues

Medical Necessity & Other Documentation Requirements. In order to ensure that Medicare beneficiaries only receive medically necessary and appropriate items and services, the Medicare program has adopted a number of documentation requirements. For example, the DME MAC Supplier Manuals provide that clinical information from the patient s medical record is required to justify the initial and ongoing medical necessity for the provision of DME. DME MAC medical directors, CMS staff and government subcontractors have taken the position, among other things, that the patient s medical record refers not to documentation maintained by the DME supplier but instead to documentation maintained by the patient s physician, healthcare facility or other clinician, and that clinical information created by the DME supplier s personnel and confirmed by the patient s physician is not sufficient to establish medical necessity. It may be difficult, and sometimes impossible, for us to obtain documentation from other healthcare providers. Moreover, auditors interpretations of these policies are inconsistent and subject to individual interpretation. This is then translated to individual supplier significant error rates and aggregated into a DMEPOS industry error rate, which is significantly higher than other Medicare provider/supplier types. High error rates lead to further audit activity and regulatory burdens. In 2012 and the first quarter of 2013, DME MACs continued to conduct extensive pre-payment reviews across the DME industry and have determined a wide range of error rates with only marginal improvement over time. For example, error rates for CPAP claims have ranged from 30% to 80%. DME MACs have repeatedly cited medical necessity documentation insufficiencies or technical deficiencies as the primary reason for claim denials. If these or other burdensome positions are generally adopted by auditors, DME MACs, other contractors or CMS in administering the Medicare program, or if non-government payors were to adopt similar positions, we would have the right to challenge these positions as being contrary to law. If these interpretations of the documentation requirements are ultimately upheld, however, it could result in our making significant refunds and other payments to Medicare and our future revenues from Medicare may be significantly reduced. We have adjusted certain operational policies to address the current expectations of Medicare, its contractors and certain other payors.

Face-to-Face Requirements. In November 2012, CMS issued a Final Rule pertaining to additional face-to-face documentation requirements associated with a variety of DMEPOS products and services. The rule was promulgated as part of the Reform Package. In it, CMS outlined the general requirements to be included in patients medical records as maintained by their physicians or healthcare practitioners in order to justify the medical necessity for DMEPOS. The requirements take effect on July 1, 2013. CMS expects to launch supplier and referral source education in the spring of 2013, and we will adjust both our policies/procedures and IT systems accordingly to comply with the new regulations. We cannot predict the adverse impact, if any, of the documentation requirements or our revised policies might have on our operations, referral source relationships, cash flow and capital resources, but such impact could be material.

Inherent Reasonableness. The Balanced Budget Act of 1997 granted authority to HHS to increase or reduce Medicare Part B reimbursement for home medical equipment, including oxygen, by up to 15% each year under an inherent

Table of Contents

reasonableness authority. Pursuant to that authority, CMS published a final rule that established a process by which such adjustments may be made. The rule applies to all Medicare Part B services except those paid under a physician fee schedule, a prospective payment system, or a competitive bidding program. Aside from a 2012 announcement by CMS to use the authority to reduce retail payment rates for diabetic supplies, a plan made moot by recent legislation, neither HHS nor CMS has issued any subsequent communication or information for several years and therefore, we cannot predict whether or when HHS would exercise its authority in this area or predict any negative impact of any such change.

The impact of increased government audits and changes in Medicare reimbursement that have been enacted to date are reflected in our results of operations for the applicable periods through March 31, 2013. We cannot estimate the combined possible impact of all retroactive audit activities, legislative, regulatory and contemplated reimbursement changes that could have a material adverse effect on our results of operations, cash flow, and capital resources. Moreover, our estimates of the impact of certain of these changes appearing in this Government Regulation section are based on a number of assumptions and are subject to uncertainties and there can be no assurance that the actual impact was not or will not be different from our estimates. However, given the ongoing, significant increases in industry audit volume and the increasing regulatory burdens associated with responding to those audits, it is likely that the negative pressures from legislative and regulatory changes will continue and accelerate.

Medicaid Reimbursement. State Medicaid programs implement reimbursement policies for the items and services we provide that may or may not be similar to those of the Medicare program. Budget pressures on these state programs often result in pricing and coverage changes and delayed payment practices that may have a detrimental impact on our operations and/or financial performance. States sometimes have interposed intermediaries to administer their Medicaid programs, or have adopted alternative pricing methodologies for certain drugs, biologicals, and home medical equipment under their Medicaid programs that reduce the level of reimbursement received by us without a corresponding offset or increase to compensate for the service costs incurred. We periodically evaluate the possibility of stopping or reducing our Medicaid business in a number of states with reimbursement or administrative policies that make it difficult for us to safely care for patients or conduct operations profitably.

Moreover, the Reform Package increases Medicaid enrollment over a number of years and imposes additional requirements on states which, combined with the current economic environment and state deficits, could further strain state budgets and therefore result in additional policy changes or rate reductions. In June 2012, the United States Supreme Court upheld the Reform Package provision expanding Medicaid eligibility to new populations as constitutional, but only so long as the expansion of the Medicaid program is optional for the states. States that choose not to expand their Medicaid programs to newly eligible populations can only lose the new federal Medicaid funding included in the Reform Package but cannot lose their eligibility for existing federal Medicaid matching payments. In view of the Supreme Court decision, some states have announced plans to reduce their Medicaid enrollments, which may have a negative impact on our revenues. We cannot currently predict the adverse impact, if any, that any such change to or reduction in our Medicaid business might have on our operations, cash flow and capital resources, but such impact could be material. In addition, we cannot predict whether states will consider similar or other reimbursement reductions, whether or how healthcare reform provisions pertaining to Medicaid will ultimately be implemented or whether any such changes would have a material adverse effect on our results of operations, cash flow and capital resources.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is comprised of a number of components pertaining to the privacy and security of certain protected health information (PHI), as well as the standard formatting of certain electronic health transactions. Many states have similar, but not identical, restrictions. Existing and any new laws or regulations have a significant effect on the manner in which we handle healthcare related data and communicate with payors. Among other provisions, the Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery and Reinvestment Act of 2009 (ARRA) includes additional requirements related to the privacy and security of PHI, clarifies and increases penalties of HIPAA and provides State Attorneys General with HIPAA enforcement authority. In January 2013, the U.S. Department of Health and Human Services released the HIPAA regulations (the Omnibus Rule) implementing the statutory amendments under the HITECH Act. The effective date of the Omnibus Rule was March 26, 2013, with a compliance date of September 23, 2013 for most provisions. Among the numerous changes the Omnibus Rule makes to the HIPAA privacy and security regulations, several specific provisions in the Omnibus Rule are likely to have significant impact. By way of example, the Omnibus Rule:

replaces the current significant risk of harm standard with a low probability of compromise standard for determining whether a security incident is reportable, which may result in more breach notifications being made.

expands the definition of marketing and, in turn, extends the range of marketing activities requiring prior written authorization.

removes an exception in the HIPAA Privacy Rule that has protected Covered Entities from liabilities associated with acts of Business Associates, even where the Covered Entity has complied with its contractual obligations and had no knowledge of the wrongdoing.

Table of Contents

makes clear the direct liability that flows to Business Associates as a result of the modifications to the HITECH Act.

We have adopted a number of policies and procedures to conform to HIPAA requirements, as modified by the HITECH Act of ARRA, throughout our operations, and we continually educate our workforce about these requirements. With such a large workforce that increasingly relies on mobile technology for daily operations, HIPAA privacy or data security is always a concern. We face potential administrative, civil and criminal sanctions if we do not comply with the existing or new laws and regulations dealing with the privacy and security of PHI. Imposition of any such sanctions could have a material adverse effect on our operations. In 2012, a Company-owned laptop containing PHI was stolen from a locked vehicle. The Company thoroughly investigated the incident and, as applicable and required by law, notified individuals and government authorities. The Company also provided the option of complimentary credit monitoring to affected individuals. At this time there have been no claims against the Company related to this incident, although the Company cannot predict whether such claims will occur in the future. The Company is taking additional steps to minimize the chances of a reoccurrence of this type of incident.

Enforcement of Healthcare Fraud and Abuse Laws. In recent years, the federal government has made a policy decision to significantly increase and accelerate the financial resources allocated to enforcing the healthcare fraud and abuse laws. Moreover, Congress adopted a number of additional provisions in the Reform Package that are designed to reduce healthcare fraud and abuse. In addition, private insurers and various state enforcement agencies have increased their level of scrutiny of healthcare claims through pre- and post-payment audit activities in an effort to identify and prosecute fraudulent and abusive practices in the healthcare area. From time to time, we may be the subject of investigations or a party to additional litigation which alleges violations of law. If any of those matters were successfully asserted against us, there could be a material adverse effect on our business, financial position, results of operations or prospects.

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Facility and Clinician Licensure. Various federal and state authorities and clinical practice boards regulate the licensure of our facilities and clinical specialists working for us, either directly as employees or on a per diem or contractual basis. Regulations and requirements vary from state to state, and in some states, we are required to make filings in connection with transactions that may be defined as a change of control. Moreover, several states are currently contemplating the establishment or expansion of facility

42

Table of Contents

licensure related to the home healthcare industry, and such changes may require us to modify our operations, particularly in multi-state service areas. We are committed to complying with all applicable licensing requirements and maintain centralized functions to manage over 4,500 facility licenses and/or permits that are required to operate our business.

Healthcare Reform. Economic, political and regulatory influences are causing fundamental changes in the healthcare industry in the United States. Various healthcare reform proposals are formulated and proposed by the legislative and administrative branches of the federal government on a regular basis. In addition, some of the states in which we operate periodically consider various healthcare reform proposals. Even with the passage of the Reform Package, we anticipate that federal and state governments will continue to review and assess alternative healthcare delivery systems and payment methodologies and public debate of these issues will continue in the future.

In June 2012, the United States Supreme Court upheld the constitutionality of the requirement in the Reform Package that individuals maintain health insurance or pay a penalty under Congress s taxing power. The Supreme Court also upheld the Reform Package provision expanding Medicaid eligibility to new populations as constitutional, but only so long as the expansion of the Medicaid program is optional for the states. Changes in the law or new interpretations of existing laws can have a substantial effect on permissible activities, the relative costs associated with doing business in the healthcare industry and the amount of reimbursement by governmental and other third-party payors. Also, the government is in the process of promulgating the implementing rules and regulations of the Reform Package, including additional requirements related to our business, our role as an employer and our customers business. Until those rules are more clearly understood, and due to uncertainties regarding the ultimate features of additional reform initiatives and their enactment and implementation over the next few years, we cannot predict whether any such reforms will have a material adverse effect on our results of operations, cash flow, capital resources and liquidity.

Iran Sanctions Related Disclosure

Under the Iran Threat Reduction and Syria Human Rights Act of 2012 (ITRSHR), which added Section 13(r) of the Exchange Act, we are required to include certain disclosures in our periodic reports if we or any of our affiliates knowingly engaged in certain specified activities during the period covered by the report. Because the SEC defines the term affiliate broadly, it includes any entity controlled by us as well as any person or entity that controls us or is under common control with us (control is also construed broadly by the SEC). We are not presently aware that we and our consolidated subsidiaries have knowingly engaged in any transaction or dealing reportable under Section 13(r) of the Exchange Act during the quarter ended March 31, 2013. In addition, we sought confirmation from companies that may be considered our affiliates as to whether they have knowingly engaged in any such reportable transactions or dealings during such period and, except as described below, are not presently aware of any such reportable transactions or dealings by such companies.

After we filed our Annual Report on Form 10-K, The Blackstone Group L.P., an affiliate of our Sponsor, informed us that its affiliate included information in its respective Annual Report on Form 10-K regarding activities that require disclosure under the ITRSHR. This disclosure is reproduced in Exhibit 99.1 of this report and is incorporated herein by reference.

Table of Contents

Results of Operations

Three Months Ended March 31, 2013 and 2012

Net Revenues. Net revenues in the three months ended March 31, 2013 were $614.7 million compared to $595.7 million in the three months ended March 31, 2012. Revenue for the three months ended March 31, 2013 increased primarily due to increased volume in the home infusion therapy segment partially offset by decreased volume in the home respiratory and home medical equipment segment.

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

Gross Profit. Gross profit margin is defined as total net revenues less total costs of total net revenues divided by total net revenues. The gross profit margin for the three months ended March 31, 2013 was 57.7%, compared to 57.8% for the three months ended March 31, 2012. The gross profit margin percentage improved in both the home respiratory and home medical equipment segment and the home infusion therapy segment. However, this improvement was offset by an increase in the revenue of the home infusion segment as a percentage of total net revenue which has a lower gross profit margin as a percentage of net revenue than the home respiratory and home medical equipment segment.

Provision for Doubtful Accounts. The provision for doubtful accounts is based on management s estimate of the net realizable value of accounts receivable. Accounts receivable estimated to be uncollectible are provided for by computing a required reserve using estimated future cash receipts based on historical cash receipts collections as a percentage of revenue. In addition, management adjusts for changes in billing practices, cash collection protocols or practices, or changes in general economic conditions, contractual issues with specific payors, new markets or products. The provision for doubtful accounts, expressed as a percentage of total net revenues, was 3.8% and 2.0% in the three months ended March 31, 2013 and March 31, 2012, respectively. Overall cash collections on gross revenue have improved during the three months ended March 31, 2013 compared to the three months ended March 31, 2012. However, the distribution of our actual write-offs has shifted to be more heavily weighted towards bad debts. This shift has resulted in an increase in our allowance for doubtful accounts and bad debt expense.

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

Selling, distribution and administrative expenses were $299.1 million, or 48.7%, of total net revenues for the three months ended March 31, 2013 compared to $317.4 million, or 53.3%, of total net revenues for the three months ended March 31, 2012.

Selling, distribution and administrative expenses decreased by $18.3 million for the three months ended March 31, 2013 compared to the three months ended March 31, 2012. The decrease was comprised of a decrease in labor costs of $14.5 million and a $3.8 million decrease in other operating expenses. For the three months ended March 31, 2013 and 2012, the corporate costs included in selling, distribution and administrative expense were $44.5 million and $50.2 million, respectively.

The decrease in labor costs of $14.5 million was primarily due to a decrease in salaries and related benefits resulting from headcount decreases associated with strategic reductions in workforce in our home respiratory therapy/home medical equipment business segment.

The decrease in other operating expenses of $3.8 million was primarily due to a decrease in employee travel and business expenses and lower professional fees due to certain 2012 corporate initiatives and corporate matters not recurring in 2013.

Amortization of Intangible Assets. Amortization of intangible assets was $0.2 million and $0.7 million in the three months ended March 31, 2013 and March 31, 2012, respectively. The decrease primarily resulted from assets becoming fully amortized during 2012.

Table of Contents

Interest Expense. Interest expense increased $0.7 million, or 2.1%, to $34.2 million in the three months ended March 31, 2013 from $33.5 million in the three months ended March 31, 2012. In April 2013, we refinanced a substantial portion of our long-term debt. The interest rate on our new debt is variable and is expected to reduce our interest expense for the remainder of 2013 based upon current market conditions.

Interest Income and Other. Interest income and other decreased to $0.5 million for the year ended March 31, 2013 from $0.7 million in the three months ended March 31, 2012.

Income Tax Expense/(Benefit). Income Tax Expense/Benefit. Our overall effective tax rate is the ratio of our tax expense (benefit) over our pre-tax income (loss) for the reporting period. Our tax expense/benefit is comprised of two items: (1) the tax computed using an Estimated Annual Effective Tax Rate (EAETR) and (2) certain tax charges and benefits which are recognized on a discrete basis in the interim period in which they occur.

Our EAETR is determined by taking into account estimated pre-tax income (loss) and permanent book/tax differences. Our EAETR is applied to year-to-date pre-tax income (loss) at the end of each interim period to compute a year-to-date tax expense (or benefit). Significant differences in our EAETR compared with statutory rates can arise from permanent book/tax differences as a percentage of our estimated pre-tax income (loss).

Our effective tax rate was (15.5)% for the three months ended March 31, 2013, compared to (4.8)% for the three months ended March 31, 2012. For the three months ended March 31, 2013 and 2012, our effective tax rate differed from federal and state statutory rates primarily due to the accrual of a valuation allowance against substantially all of our net deferred tax assets.

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

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

Beginning with the year ended December 31, 2011, we accrued a valuation allowance against substantially all of our net deferred tax assets since we determined that it is more likely than not that substantially all of the our net deferred tax assets will not be realized. We intend to maintain our valuation allowance until sufficient positive evidence exists to support the reversal of all or a portion of its valuation allowance.

We increased our valuation allowance by $0.3 million to $238.8 million at March 31, 2013 from $238.5 million at December 31, 2012 to offset corresponding increases in our net deferred tax assets for the three months ended March 31, 2013.

Segment Net Revenues and EBIT

Segment financial results are based on directly assignable net revenues, cost of goods sold, bad debt expenses and selling, distribution and administrative costs, where available. Costs that are not directly assignable, such as corporate costs and certain selling, distribution and administrative expenses, are allocated based on various metrics including billed census, headcount and branch locations by segment, among others.

During the fourth quarter of 2012, we revised our allocation to reporting segments. This allocation is based on how we currently manage and discuss our operations.

Table of Contents

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

	Net Revenues			
(in thousands)	Three Months Ended March 31, 2013	Percentage of Net Revenues	Three Months Ended March 31, 2012	Percentage of Net Revenues
Operating Segment				
Home respiratory therapy and home medical equipment	$ 298,525	48.6%	$ 300,898	50.5%
Home infusion therapy	316,230	51.4	294,815	49.5
Total	$ 614,755	100.0%	$ 595,713	100.0%

	EBIT			
(in thousands)	Three Months Ended March 31, 2013	Percentage of Net Revenues	Three Months Ended March 31, 2012	Percentage of Net Revenues
Operating Segment				
Home respiratory therapy and home medical equipment	$ 584	0.2%	$ (16,000)	(5.3)%
Home infusion therapy	31,479	10.0%	30,106	10.2%
Total	$ 32,063		$ 14,106	

See definition and reconciliation of EBIT to net loss included at the end of this section.

Home Respiratory Therapy and Home Medical Equipment Segment. For the home respiratory therapy and home medical equipment segment total net revenues decreased $2.4 million, or 0.8%, to $298.5 million in the three months ended March 31, 2013 from $300.9 million in the three months ended March 31, 2012. Revenues for the home respiratory therapy and home medical equipment segment decreased to 48.6% of total revenue in the three months ended March 31, 2013 from 50.5% in the three months ended March 31, 2012.

Home respiratory therapy revenues are derived primarily from the provision of oxygen systems, obstructive sleep apnea equipment, home ventilators, nebulizers, respiratory medications and related services. Revenues from the home respiratory therapy service line decreased by 1.5% in the three months ended March 31, 2013 compared to the three months ended March 31, 2012. The decrease in revenue resulted primarily from a decrease in other respiratory therapy revenue due to a decrease in nebulizer and ventilator volume.

Home medical equipment revenues are derived from the rental and sale of equipment to assist patients with ambulation, safety and general care in and around the home. Home medical equipment revenues increased by 3.2% in the three months ended March 31, 2013 compared to the three months ended March 31, 2012. The increase was primarily due to an increase in the volume of negative pressure wound therapy products partially offset by a decrease in the volume of other home medical equipment products.

EBIT for the home respiratory therapy and home medical equipment segment in the three months ended March 31, 2013 was $0.6 million compared to a negative $16.0 million in the three months ended March 31, 2012. EBIT was 0.2% of segment net revenues in the three months ended March 31, 2013 compared to negative 5.3% of segment net revenues in the three months ended March 31, 2012. The increase in the EBIT as a percentage of segment net revenues for the three months ended March 31, 2012 to the three months ended March 31, 2013 is primarily due to a decrease in sales, distribution and administrative costs as a percentage of net revenue partially offset by an increase in the provision for doubtful accounts as a percentage of net revenues in the three months ended March 31, 2013 compared to the three months ended March 31, 2012.

Home Infusion Therapy Segment. For the home infusion therapy segment, total net revenues increased $21.4 million, or 7.3% to $316.2 million for the three months ended March 31, 2013 from $294.8 million in the three months ended March 31, 2012. Revenues for the home infusion therapy segment increased to 51.4% of total revenue in the three months ended March 31, 2013 from 49.5% in the three months ended March 31, 2012.

The home infusion therapy segment involves the administration of drugs or nutrients directly into the body intravenously through a needle or catheter. Infusion therapy services also include administering enteral nutrients directly into the gastrointestinal

Table of Contents

tract through a feeding tube. The growth in home infusion therapy revenue resulted primarily from an increase in the overall volume of specialty drugs.

EBIT for the home infusion therapy segment in the three months ended March 31, 2013 was $31.5 million compared to $30.1 million in the three months ended March 31, 2012. EBIT was 10.0% of segment net revenues in the three months ended March 31, 2013 compared to 10.2% of segment net revenues in the three months ended March 31, 2012. The decrease in EBIT as a percentage of net segment revenues for the three months ended March 31, 2012 to the three months ended March 31, 2013 is 0.7% and is primarily due to an increase in the provision for doubtful accounts as a percentage of segment net revenues in the three months ended March 31, 2013 compared to the three months ended March 31, 2012, partially offset by an increase in the gross profit margin as a percentage of segment net revenues and a decrease in sales, distribution and administrative costs as a percentage of net revenues in the three months ended March 31, 2013 compared to the three months ended March 31, 2012.

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

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

(in thousands)	Three Months Ended March 31, 2013	Three Months Ended March 31, 2012
Net loss	$ (1,893)	$ (19,607)
Interest expense, net	33,702	32,815
Income tax expense (benefit)	254	898
EBIT	$ 32,063	$ 14,106

Liquidity and Capital Resources

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

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

(in thousands)	Three Months Ended March 31, 2013	Three Months Ended March 31, 2012
Net cash provided by operating activities	$ 27,419	$ 17,856
Net cash used in investing activities	(25,902)	(33,352)
Net cash (used in) provided by financing activities	(13,074)	9,914
Net decrease in cash and equivalents	(11,557)	(5,582)
Cash and equivalents at beginning of period	27,080	29,096
Cash and equivalents at end of period	$ 15,523	$ 23,514

In the three months ended March 31, 2013, our free cash flow was $1.5 million. For the three months ended March 31, 2012 our free cash flow was $(15.4) million. See discussion below on changes in the components of free cash flow; net cash provided by operations and purchases of patient service equipment and property, equipment and improvements. Free cash flow is a financial measure which is not calculated in accordance with GAAP. Free cash flow is defined as cash provided by operating activities less purchases of patient service equipment and

property, equipment and improvements, net of proceeds from the sale of patient service equipment and other exclusive of effects of acquisitions. It is presented as a supplemental performance measure and is not intended as an alternative to any other cash flow measure calculated in accordance with GAAP. Further, free cash flow may not be comparable to similarly titled measures used by other companies.

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

Table of Contents

(in thousands)	Three Months Ended March 31, 2013	Three Months Ended March 31, 2012
Reconciliation Free Cash Flow:		
Net loss	$ (1,893)	$ (19,607)
Non-cash items	49,126	39,636
Change in operating assets and liabilities	(19,814)	(2,173)
Net cash provided by operating activities	27,419	17,856
Less: Purchases of patient service equipment, property, equipment and improvements net of proceeds from sale of patient service equipment and other	(25,902)	(33,258)
Free cash flow	$ 1,517	$ (15,402)

The Three Months Ended March 31, 2013 Results Compared to the Three Months Ended March 31, 2012

Net cash provided by operating activities in the three months ended March 31, 2013 was $27.4 million compared to $17.9 million in the three months ended March 31, 2012, an increase of $9.6 million. The increase in net cash provided by operating activities resulted from a $27.2 million increase in the provision of cash from net income and non-cash items to a $47.2 million provision in 2013 from a $20.0 provision in 2012, partially offset by a $17.6 million increase in cash used related to the change in operating assets and liabilities to a $19.8 million use of cash in 2013 from a $2.2 million use of cash in 2012.

The $17.6 million increase in cash used by the change in operating assets and liabilities consisted primarily of the following:

- $21.4 million increase in cash used by accounts payable to a $6.4 million use of cash in the three months ended March 31, 2013 from a $15.1 million provision of cash in the three months ended March 31, 2012. The increase was primarily due to the timing of payments on invoices.

- $5.5 million increase in cash used by prepaid expenses and other assets to a $8.0 million use of cash in the three months ended March 31, 2013 from a $2.6 million use of cash in the three months ended March 31, 2012. The increase was primarily due to the prepayment of our sponsor management fee.

Offset by:

- $8.5 million decrease in cash used by accounts receivable to a $28.6 million use of cash in the three months ended March 31, 2013 from a $37.1 million use of cash in the three months ended March 31, 2012. The decrease was primarily due to our continuing focus on improvement of our billing and collections function.

Net cash used in investing activities in the three months ended March 31, 2013 was $25.9 million, compared to $33.4 million in the three months ended March 31, 2012. The primary use of funds in 2013 was $36.9 million to purchase patient service equipment and property equipment and improvements; $29.5 million related to patient service equipment to support revenue growth; and $7.4 million related to property equipment and improvements, primarily due to additions to our information systems software and hardware. This was partially offset by proceeds from the sale of patient service equipment and other of $11.0 million. The primary use of funds in 2012 was $44.8 million to purchase patient service equipment and property equipment and improvements; $36.0 million related to patient service equipment; and $8.8 million related to property equipment and improvements, primarily due to additions to our information systems software and hardware. This was partially offset by proceeds from the sale of patient service equipment and other of $11.5 million.

In 2013, net cash used by financing activities in the three months ended March 31, 2013 was $13.1 million compared to $9.9 million provision of cash in the three months ended March 31, 2012. Cash used in financing activities in 2013 and 2012 primarily related to net borrowings on our ABL facility.

Accounts Receivable. Accounts receivable before allowance for doubtful accounts increased to $410.3 million as of March 31, 2013 from $397.4 million at December 31, 2012. Days sales outstanding (calculated as of each period-end by dividing accounts receivable, less allowance

for doubtful accounts, by the rolling average of total net revenues) were 51 days at March 31, 2013 and at December 31, 2012. The increase in accounts receivable is primarily due to an increase in patient pay accounts receivable due to the normal seasonality of patient deductibles and copays.

Table of Contents

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

	March 31, 2013	December 31, 2012
Total	20.6%	21.8%
Medicare	12.4%	17.2%
Medicaid	14.0%	15.7%
Patient self pay	28.2%	31.5%
Managed care/other	22.5%	22.5%

Unbilled Receivables. Included in accounts receivable are earned but unbilled receivables of $56.8 million at March 31, 2013 and December 31, 2012. Delays, ranging from a day up to several weeks, between the date of service and billing can occur due to delays in obtaining certain required payor-specific documentation from internal and external sources. Earned but unbilled receivables are aged from date of service and are considered in our analysis of historical performance and collectability.

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

Long-term Debt.

Series A-1 Notes and Series A-2 Notes. We issued the Series A-1 Notes and Series A-2 Notes in May 2009 and August 2009, respectively. On April 5, 2013, all Series A-1 Notes and $160.0 million of Series A-2 Notes were refinanced. See *Recent Developments.*

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

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

transfer or sell assets.

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

Substantially all of the Company s 100%-owned subsidiaries (the Guarantors) jointly and severally, unconditionally guarantee the Series A-1 Notes and the Series A-2 Notes on a senior secured basis. The Guarantors also guarantee the Company s ABL Facility.

Amended and Restated ABL Facility. On August 8, 2011, we entered into a senior secured asset-based revolving credit facility, or ABL Facility, with Bank of America, N.A., as administrative agent and collateral agent and a syndicate of financial institutions and institutional lenders. The ABL Facility amended and restated our prior senior secured asset-based revolving credit facility dated October 28, 2008, which provided for a revolving credit financing of up to $150.0 million.

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

Table of Contents

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

Borrowings under our ABL Facility bear interest at a rate per annum equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the prime rate of Bank of America, N.A. and (2) the federal funds effective rate plus 1/2 of 1% (Base Rate), plus an applicable margin (currently 1.25%) or (b) a LIBOR rate determined by reference to LIBOR, adjusted for statutory reserve requirements, plus an applicable margin (currently 2.25%). The applicable margin for borrowings under our ABL Facility is subject to (a) 25 basis points step ups and step downs based on average excess availability under the ABL Facility and (b) a step down of 25 basis points based on achieving a consolidated fixed charge coverage ratio greater than 1.75 to 1.00. In addition to paying interest on outstanding amounts under our ABL Facility, we are required to pay a commitment fee, in respect of the unutilized commitments thereunder, ranging from 0.375% to 0.50% per annum, which fee will be determined based on utilization of our ABL Facility (increasing when utilization is low and decreasing when utilization is high). We also pay customary letter of credit fees equal to the applicable margin on LIBOR loans and other customary letter of credit and agency fees.

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

As of March 31, 2013, there was $12.0 million outstanding under the ABL Facility, outstanding letters of credit totaled $23.6 million and additional availability under the ABL Facility, subject to the borrowing base, was $214.4 million. As of March 31, 2013, the available borrowing base did not constrain our ability to borrow the entire $214.4 million of available borrowing capacity under our ABL Facility. At March 31, 2013, we were in compliance with all of the financial covenants required by the credit agreement governing the ABL Facility. As of April 26, 2013, there was approximately $55.0 million outstanding under the ABL Facility. Under the terms of our ABL Facility, loans outstanding under the ABL Facility may be accelerated if any Series A-2 Notes remain outstanding on or after August 1, 2014.

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

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

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

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

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

Table of Contents

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

(in thousands)	Three Months Ended March 31, 2013	Twelve Months Ended March 31, 2013
Net loss(a)	$ (1,893)	$ (242,702)
Interest expense, net(b)	33,702	134,406
Income tax benefit	254	(131,549)
Depreciation and amortization	26,547	111,135
Non-cash impairment charges(c)		350,000
Non-cash items(d)	6,242	22,801
Costs incurred related to initiatives and non-recurring items(e)	4,493	30,735
Other adjustments (f)	1,749	6,996
Projected cost savings and synergies(g)	1,086	5,328
Adjusted EBITDA	$ 72,180	$ 287,150

(a) Net loss for the twelve months ended March 31, 2013 reflects the following non-cash impairment charges based on the results of our 2012 annual impairment testing and the tax impact associated with the impairment charge:

(i) Trade name impairment of $350.0 million, $270.0 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $80.0 million which relates to the home infusion therapy reporting unit; and

(ii) Tax benefit of $131.6 million relating to the intangible impairment.

All of these items resulted in a $218.4 million increase in our net loss in the twelve months ended March 31, 2013.

Net loss for the twelve months ended March 31, 2013 consists of the following quarterly net loss amounts: $(12,736) for the three months ended June 30, 2012; $(175,711) for the three months ended September 30, 2012; $(52,362) for the three months ended December 31, 2012; and $(1,893) for the three months ended March 31, 2013.

(b) Reflects $34.2 million of interest expense, net of $0.5 million of interest income for the three months ended March 31, 2013. Reflects $135.7 million of interest expense, net of $1.3 million of interest income for the twelve months ended March 31, 2013.

(c) Reflects the $350.0 million non-cash impairment described in (a) above.

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

(in thousands)	Three Months Ended March 31, 2013	Twelve Months Ended March 31, 2013
Profit interest units compensation expense	$ 1,321	$ 4,100
Loss on patient service equipment, disposition of assets and other(i)	4,921	18,701
Total non-cash items	$ 6,242	$ 22,801

(i) Primarily represents the net book value of our patient service equipment upon sale, disposal or write-off, which is a non-cash expense included within cost of net revenues in our consolidated statements of operations.

(e) Costs incurred related to initiatives and non-recurring items are comprised of the following:

(in thousands)	Three Months Ended March 31, 2013	Twelve Months Ended March 31, 2013
Costs and expenses related to initiatives(i)	$ 4,493	$ 27,329
Acquisition of Praxair assets(ii)		215
Executive severance and retention(iii)		5,513
Other(iv)		(2,322)
Total costs incurred related to initiatives and non-recurring items	$ 4,493	$ 30,735

(i) Represents salaries and wages, severance, relocation consulting fees and other expenses for the three and twelve months ended March 31, 2013, primarily related to six projects: (1) professional fees related to certain corporate

Table of Contents

matters; (2) a new billing and collections system for our home infusion therapy business; (3) sales force and operations optimization; (4) the offshoring and subsequent onshoring of certain of our billing and collections functions; and (5) centralization of our admissions process for our home infusion therapy business.

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

(iii) Represents executive severance and retention expense as a result of the Merger for the three and twelve months ended March 31, 2013.

(iv) Represents a settlement related to a prior acquisition.

(f) Other adjustment items primarily related to the sponsor management fee of $1.8 million and $7.0 million for the three and twelve months ended March 31, 2013.

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

Business Combinations and Asset Purchases. We periodically acquire complementary businesses. These transactions are accounted for as purchases and the results of operations of the acquired companies are included in the accompanying statements of operations from the dates of acquisition. Covenants not to compete are being amortized over the life of the respective agreements. Customer lists, favorable lease arrangements and patient referral sources are being amortized over the period of their expected benefit. During the three months ended March 31, 2013 and March 31, 2012, the Company purchased certain assets of a business for $0.0 million and $0.1 million, respectively.

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

Contractual Cash Obligations. The following table summarizes the long-term cash payment obligations to which we are contractually bound. The years presented below represent a 9-month period ending December 31, 2013 and 12-month periods in subsequent periods.

(in millions)	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years	Totals
Series A-1 Notes(5)	$	$ 700	$	$	$ 700
Series A-2 Notes(5)		318			318
Amended ABL Facility(1)(2)	12				12
Interest Payments on Series A-1 Notes(3)(5)	79	79			158
Interest Payments on Series A-2 Notes(4)(5)	39	39			78
Fees on ABL Facility(2)(6)	2	1			3
Operating Leases	42	90	51	14	197
Capitalized Leases(9)					
Purchase Obligations(7)	30	68	50	29	177
Unrecognized Tax Benefits(8)					
Total Contractual Cash Obligations	$ 204	$ 1,295	$ 101	$ 43	$ 1,643

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

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

(3) Represents aggregate interest payments on $700.0 million of the Series A-1 Notes issued in May 2009 that is paid semi-annually in May and November. Interest payments on the Series A-1 Notes will total approximately $79 million annually until the Series A-1 Notes mature on November 1, 2014. The effective interest rate at September 30, 2012 was 11.25%.

Table of Contents

(4) Represents aggregate interest payments on $317.5 million of the Series A-2 Notes issued in August 2009 that is paid semi-annually in May and November. Interest payments on the Series A-2 Notes will total approximately $39 million annually until the Series A-2 Notes mature on November 1, 2014. The effective interest rate at September 30, 2012 was 12.375%.

(5) On April 5, 2013, we entered into a senior secured credit agreement (Credit Agreement) and borrowed $900.0 million in aggregate principal amount of term loans from the lenders under this credit agreement. On April 5, 2013, we provided a notice of redemption for all of our outstanding Series A-1 Notes and an aggregate principal amount of $160.0 million of the outstanding Series A-2 Notes. Such redemptions are expected to occur on May 6, 2013. The impact of these financing transactions has not been reflected in the table above.

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

(7) The purchase obligations primarily relate to approximately $142 million we expect to pay under an agreement with Dell Services (formerly Perot Systems) and approximately $33 million we expect to pay under an agreement with Intelenet. However, if we terminated the agreements, the required obligation to vendors could be reduced to approximately $13.2 million for Dell Systems and $6.7 million for Intelenet.

(8) Gross unrecognized tax benefits of $7.1 million are included within *Income Taxes Payable and Other Non-current Liabilities* in the total liabilities section of our March 31, 2013 consolidated balance sheet. The entire $7.1 million amount is not reflected in the contractual cash obligations table above since we cannot make a reliable estimate of the period in which cash payments will occur.

(9) Less than $1 million.

Off-Balance Sheet Arrangements

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

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

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

At March 31, 2013, there was $12.0 million outstanding under our ABL Facility. As of April 26, 2013, there was approximately $55.0 million outstanding under the ABL Facility. The credit agreement governing the ABL Facility provides interest rate options based on the following indices: Federal Funds Rate, the Bank of America prime rate or LIBOR. All such interest rate options are subject to the application of an interest margin as specified in the credit agreement governing the ABL Facility. At March 31, 2013, any outstanding borrowings under the ABL Facility would have been tied to the Bank of America prime rate. See *Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources Long-term Debt*. In addition, on April 5, 2013, we borrowed $900.0 million in aggregate principal amount of term loans under the new senior secured credit agreement. Borrowings under the Credit Agreement bear interest at a fluctuating rate per annum equal to, at the Company s option (i) a base rate equal to the highest of (a) the federal funds rate plus 1/2 of 1%, (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America, N.A. as its prime rate and (c) the one month LIBOR Rate plus 1.00% (provided that in no event shall such base rate with respect to the initial Term Loans be less than 2.25% per annum), in each case plus an applicable margin of 4.50% or (ii) a LIBOR Rate for the applicable interest period (provided that in no event shall such LIBOR rate with respect to the initial Term Loans be less than 1.25% per annum) plus an applicable margin of 5.50%.

Table of Contents

ITEM 4. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

We maintain disclosure controls and procedures that are designed to ensure that information required to be disclosed in the Company s reports under the Securities Exchange Act of 1934, as amended (Exchange Act) is recorded, processed, summarized and reported within the time periods specified in the SEC s rules and forms, and that such information is accumulated and communicated to the Company s management, including the Company s Chief Executive Officer and Principal Financial Officer, as appropriate, to allow timely decisions regarding required disclosure. Any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. The Company s management, with the participation of the Company s Chief Executive Officer and Principal Financial Officer, has evaluated the effectiveness of the design and operation of the Company s disclosure controls and procedures as of the end of the period covered by this Form 10-Q. Based upon that evaluation, the Company s Chief Executive Officer and Principal Financial Officer concluded that, as of March 31, 2013, the Company s disclosure controls and procedures were effective to accomplish their objectives at the reasonable assurance level.

Changes in Internal Control over Financial Reporting

Except as described below, there was no change in the Company s internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three month period ended March 31, 2013 covered by this Quarterly Report on Form 10-Q that has materially affected, or is reasonably likely to materially affect, the Company s internal control over financial reporting.

As previously described in the Company s Annual Report on Form 10-K for the fiscal year ended December 31, 2012, management concluded that the following deficiency constituted a material weakness in our internal control over financial reporting as of December 31, 2012:

> In our process of assessing the appropriate accounting treatment for the reporting of cash receipts related to the sale of patient service equipment in our consolidated statements of cash flows, we did not effectively design and perform control activities to prevent or detect material misstatements that might exist in our presentation of cash receipts from the sale of patient service equipment on the consolidated statement of cash flows.

Subsequent to December 31, 2012, we have taken steps to expand the awareness of the relevant GAAP requirements by members of our personnel involved in the preparation and review of our financial statements. We believe these steps have improved the effectiveness of our internal control over financial reporting and have remediated the previously identified material weakness.

Table of Contents

Part II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

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

ITEM 1A. RISK FACTORS

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

Risks Relating to Our Business

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

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

CMS was required to conduct the Round 1 Rebid and mandated certain changes for both the Round 1 Rebid and subsequent rounds of the program. Approximately $16.6 million of our net revenues for the year ended December 31, 2012 was generated by the products and CBAs included in the Round 1 Rebid, net of both the average price reduction of 32% as reported by CMS and volume fluctuations in the markets over the first two years of the three-year contract. When the additional products to be included in the more recent Round 1 Recompete process are accounted for, the same markets generated approximately $20.1 million in the year ended December 31, 2012. The Round 1 Recompete phase of the program takes effect in January 2014. Round 2 will include the majority of the same product categories as the Round 1 Rebid, but also include (i) a new product category including standard power wheelchairs and manual wheelchairs, (ii) Negative Pressure Wound Therapy, (iii) Support Surfaces (Group 2 mattresses and overlays) in all Round 2 markets and (iv) a national mail order competition for diabetic supplies. CMS announced the Single Payment Amounts (SPAs) for Round 2 on January 30, 2013, and began the contract offer process. On April 9, 2013 CMS announced the Round 2 contract suppliers. We were offered a significant number of contracts in Round 2 and estimate that approximately $122 million of our net revenues for the fiscal year ending December 31, 2012 are subject to Round 2 competitive bidding. CMS reported that the average payment reduction for Round 2 will be 45%. After applying the actual SPAs for each impacted CBA to Apria s actual 2012 revenue for the product categories included in the bidding program, the Company estimates that the Round 2 revenue reduction is $57 million before any changes in volume are accounted for. The extent of the industry-wide competitive bidding reductions will likely have a profound effect on our competitors as well as ourselves.

In April 2012, CMS announced the timeline and product categories for the Round 1 Rebid Recompete. Bidding for this round included a deadline of December 14, 2012 by which to submit bids and CMS is targeting the Spring of 2013 to announce the SPAs for this round. The new rates for this round are scheduled to take effect on January 1, 2014. We cannot estimate the impact of Round 1 Recompete s new rates on our business until the government publishes the results of that bidding round. The Reform Package also made changes to the competitive bidding program and gave the Secretary of Health and Human Services the authority to apply competitive bid pricing to non-bid areas after a rulemaking process, effective in 2016. At this time, we cannot quantify what negative impact, if any, future program revisions will have upon our revenue or operations, but such impact would likely be material.

Further, the DRA resulted in reduced reimbursement rates for certain durable medical equipment, including the home oxygen equipment and services we provide, a reduced period for rental revenue, and potential increased costs to us associated with

Table of Contents

replacement of certain patient-owned equipment. There have been various administrative and legislative proposals to further reduce the maximum capped rental period for oxygen equipment below the 36-month level mandated by the DRA to 13 and 18 months, respectively, and/or to reduce the monthly payment rates for oxygen equipment.

There are also ongoing state and federal legislative and regulatory efforts to reduce or otherwise adversely affect Medicaid reimbursement rates for products and services we provide. For a number of years, some states have adopted alternative pricing methodologies for certain drugs, biologicals and home medical equipment reimbursed under the Medicaid program. In a number of states, the changes reduced the level of reimbursement we received for these items without a corresponding offset or increase to compensate for the service costs we incurred. We periodically evaluate the possibility of stopping or reducing our Medicaid business in a number of states with reimbursement policies that make it difficult for us to conduct operations profitably.

Moreover, the Reform Package increases Medicaid enrollment over a number of years and imposes additional requirements on states, which could further strain state budgets and therefore result in additional policy changes or rate reductions. In June 2012, the United States Supreme Court upheld the Reform Package provision expanding Medicaid eligibility to new populations as constitutional, but only so long as the expansion of the Medicaid program is optional for the states. States that choose not to expand their Medicaid programs to newly eligible populations can only lose the new federal Medicaid funding included in the Reform Package but cannot lose their eligibility for existing federal Medicaid matching payments. In addition, changes to the federal regulations pertaining to prescription drug pricing may also impact the Medicare and Medicaid reimbursement available to us. The President s 2013 and 2014 fiscal budget proposals would limit the state Medicaid reimbursement levels for certain durable medical equipment services and products to Medicare reimbursement rates for the same products and services in the same state, including those impacted by the Medicare DMEPOS competitive bidding program. In view of the Supreme Court decision, some states have announced plans to reduce their Medicaid enrollments, which may have a negative impact on our revenues. We cannot currently predict the adverse impact, if any, that any such changes to or reduction in our Medicaid business might have on our operations, cash flow and capital resources, but such impact could be material. In addition, we cannot predict whether other states will consider similar or other reimbursement reductions or whether any such changes could have a material adverse effect on our results of operations, cash flow and capital resources.

We cannot estimate the ultimate impact of all legislated and contemplated Medicare and Medicaid reimbursement changes or provide assurance to investors that additional reimbursement reductions will not be made or will not have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity. However, given the recent significant increases in industry audit volume, auditors interpretation and enforcement of documentation requirements and the increasing regulatory burdens associated with responding to those audits, it is likely that the negative pressures from legislative and regulatory changes will continue and accelerate.

For further information, see *Business Government Regulation*.

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

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

There are various provisions in the Reform Package that impact our business. For example, the Reform Package requires certain pharmaceutical and medical device manufacturers to pay an excise tax to the government, which may, in turn, increase our costs for these products. However, new legislation aimed at repealing the medical device excise tax, the Protect Medical Innovation Act of 2013 , was introduced in the House in February 2013 and has been referred to the House Ways and Means Committee. The Reform Package also provides for cuts in some Medicare payments made to certain providers and substantial cuts to Medicare Advantage plans, through which we contract to provide services to Medicare beneficiaries. Also included in the Reform Package are (i) an expansion of the Recovery Audit Contractor Program, (ii) certain fraud and abuse prevention measures and (iii) expanded regulatory authority concerning the types of conduct that can result in additional fines and penalties for those healthcare providers who do not comply with applicable laws and regulations. Furthermore, the Reform Package grants the Secretary of Health and Human Services authority to set a date by which certain providers and suppliers will be required to establish a compliance program.

56

Table of Contents

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

In an effort to further strengthen the integrity of the Medicare program, the Reform Package includes additional requirements concerning physician enrollment and certain mandatory face-to-face patient/physician visits in conjunction with the ordering of durable medical equipment. These provisions have been and will continue to be the subject of rulemaking and are a high priority for the American Association for Homecare and other industry representative organizations. We expect the Administration to continue to enhance its oversight efforts and we strive to incorporate any necessary changes into its overall policies, procedures, corporate compliance and internal audit programs on a regular basis.

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

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

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

As a result of continuing reductions in payor reimbursement, we, like many other healthcare companies, are making substantial efforts to reduce our costs in providing healthcare services and products. Many managed care organizations and insurers also regularly attempt to seek reductions in the prices at which we provide services to them and their patients. Some managed care organizations and insurers also propose to limit coverage for our products and services and implement onerous payment rules, policies, administrative burdens, audits and other requirements that adversely impact our reimbursement and increase our costs of providing services and products. In addition to this increasing pressure to reduce costs, the use by managed care payors of benefit managers and other intermediaries is also increasing and may adversely impact us, including for example by imposing of burdensome reimbursement or utilization management policies we must comply with and adverse changes in our participation status with managed care organizations and insurers. We have a large number of contractual arrangements with managed care organizations and other parties, which represented approximately 71% and 70% of our total net revenues for the three months ended March 31, 2013 and 2012, respectively, and we expect that we will continue to enter into more of these contractual arrangements. Many of these contracts allow, usually after due notice, for payors to alter their payment policies (or newly enforced policies that were previously enacted). We could be materially adversely affected by adverse payment policy practices. Also, the Reform Package significantly reduces the government s payment rates to Medicare Advantage plans. Other provisions impose minimum medical-loss ratios, state and federal premium review procedures and benefit requirements on insurers. Mandatory sequestration and its associated price reductions will accelerate the risk of further pricing pressure on managed care payors and on us. These public policy changes have unpredictable effects on the insurance industry on which we rely. There can be no assurance that we will retain or obtain Medicare Advantage or other such managed care contracts or that such plans will not attempt to further reduce the rates they pay to providers. In addition, if we are unable to successfully reduce our costs, we may be unable to continue to provide services directly to patients of certain payors or through these contractual arrangements. This would have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

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

Table of Contents

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

We are subject to many stringent and frequently changing laws and regulations, and interpretations thereof, at both the federal and state levels, requiring compliance with burdensome and complex billing and payment, substantiation and record-keeping requirements. Examples of such documentation requirements are contained in the DME MAC supplier manuals which provide that clinical information from the patient s medical record is required to justify the medical necessity for the provision of DME. DME MAC medical directors, CMS staff and government auditors have taken the position, among other things, that the patient s medical record refers not to documentation maintained by the DME supplier but instead to documentation maintained by the patient s physician, healthcare facility, or other clinician, and that clinical information created by the DME supplier s personnel and confirmed by the patient s physician is not sufficient to establish medical necessity. It may be difficult, and sometimes impossible, for us to obtain such documentation from other healthcare providers. Also, auditors interpretations of these policies are inconsistent and subject to individual interpretations leading to high supplier and industry error rates. In 2012 and early 2013, DME MACs continued to conduct significant pre-payment reviews across the DME industry and have determined a wide range of error rates. For example, error rates for CPAP claims have ranged from 30% to 80%. DME MACs have repeatedly cited medical necessity documentation insufficiencies as the primary reason for claim denials. In addition, certain states have established unique documentation requirements concerning direct patient care activities provided by DME suppliers staff. In the absence of such documentation, the state may request a refund or impose sanctions such as fines. If these or other challenging positions continue to be adopted by auditors, DME MACs, states, CMS or its contractors in administering the Medicare program, we have the right to contest these positions as being contrary to law. Such appeal processes may be protracted and costly, even when the initial determinations are overturned. If these interpretations of the documentation requirements are ultimately upheld, it could result in our making significant refunds and other payments to Medicare and/or Medicaid and our future revenues from Medicare and/or Medicaid would likely be reduced. We cannot currently predict the adverse impact, if any, that these new, more onerous interpretations of the Medicare and/or Medicaid documentation requirements, or revised internal operational policies to address them, might have on our relationships with referral sources, operations, cash flow and capital resources, but such impact could be material.

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

The Reform Package also includes certain fraud and abuse prevention measures and expands regulatory authorities concerning the types of conduct that can result in additional fines and penalties for those healthcare providers who do not comply with applicable laws and regulations. In July 2012, CMS opened its Program Integrity Command Center which is designed to build and improve sophisticated predictive analytics that identify and combat fraud. Although we cannot quantify at this time what, if any, impact such processes might have on our relationships with referral sources, operations, cash flow and capital resources, such impact could be material.

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

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

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

Table of Contents

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

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

Along with other healthcare providers and suppliers, we have been subject to a significant increase in the number of audits conducted under these new programs. Many of these audits have ascribed error rates to our audited locations that are significantly higher than we, and others in the industry, have experienced in the past. In some cases, these high error rates appear to be based on the auditors incomplete or erroneous review of our submitted documentation, our inability to retrieve physician or hospital documentation from their records, the auditors enforcement of requirements for documentation for patients begun on service during a time period when lesser levels of documentation were accepted practice, or unclear scoring methodologies used by the auditors, among other factors. In other instances, high error rates have resulted from the auditors use of more stringent or brand-new interpretations of the types of medical necessity documentation required for CMS to pay for the services we provide. We have appealed the results of certain of these audits and made changes to our operating policies and procedures, but cannot predict the ultimate impact that the government s expanded and more stringent auditing, or our policies, may have on our business, financial conditions or results of operations.

We have been informed by these auditors that other healthcare providers and all suppliers of certain DMEPOS product categories are expected to experience further increased scrutiny from these audit programs. When a government auditor ascribes a high error rate to one or more of our locations, it generally results in a protracted pre-payment claims review, payment delays, refunds and other payments to the government and/or our need to request more documentation from referral sources than has historically been required. It may also result in additional audit activity in other locations of ours in that state or DME MAC jurisdiction. Our error rate, aggregated with other DMEPOS suppliers in the industry, is then reported to Medicare contractors and Congress. According to the CERT contractors utilizing the more stringent interpretations of the medical necessity documentation requirements, the DMEPOS industry error rate increased in recent years, from 51.9% in 2009 to 66% in 2012. Further, DME MACs have continued to conduct extensive pre-payment reviews across the DME industry and, for example, have found that error rates for CPAP claims have ranged from 30% to 80%. We cannot currently predict the adverse impact, if any, these new audits, methodologies and interpretations might have on our operations, cash flow and capital resources, but such adverse impact could be material.

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

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

We launched a substantial multi-year cost reduction plan in late 2007 across a number of identified initiatives realizing approximately $202.8 million in annualized pre-tax savings through March 31, 2013. As of March 31, 2013 we have approximately $5.3 million of projected costs savings and synergies remaining. Because of the ongoing reimbursement pressures on our industry, we plan to implement additional changes in our operating model to further reduce our costs. Projected cost savings associated with our future initiatives are subject to a variety of risks, including:

- the contemplated costs to effect these initiatives may exceed estimates;
- the initiatives we are contemplating may require consultation with various customers, employees or regulators, and such consultations may influence the timing, costs and extent of expected savings;

the loss of skilled employees in connection with the initiatives; and

the projected savings contemplated under these programs may fall short of targets.

Table of Contents

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

We continue to seek opportunities to streamline our organizational structure and operations. We have initiated certain steps designed to further separate our two reporting units to enable them to function more autonomously and achieve certain operating efficiencies. We expect these efforts to continue throughout 2013. If we fail to implement our reorganization plans, at the cost or within the time periods expected, we may not be able to achieve the expected results. In addition, we may incur substantial costs in connection with our reorganization plans.

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

We have identified a number of areas throughout our operations where we intend to modify the current processes or systems in order to attain a higher level of productivity or ensure compliance. The ultimate cost savings expected from the successful design and implementation of such initiatives will be necessary to help offset the impact of Medicare and Medicaid reimbursement reductions and continued downward pressure on pricing. Additionally, Medicare and Medicaid often change their documentation requirements. The standards and rules for healthcare transactions, code sets and unique identifiers also continue to evolve, such as ICD 10 and HIPAA 5010 and other data security requirements. Moreover, government programs and/or commercial payors may have difficulties administering new standards and rules for healthcare transactions and this may adversely affect timelines of payment or payment error rates. The DMEPOS competitive bidding program also imposes new reporting requirements on contracted providers. From time to time, our outsourced contractor for certain information systems functions, Dell Services, makes operational, leadership or other changes that could impact our plans and cost-savings goals. Our failure to successfully design and implement system or process modifications could have a significant impact on our operations and financial condition. The implementation of many of the new standards and rules will require us to make substantial investments. Further, the implementation of these system or process changes could have a disruptive effect on related transaction processing and operations. If our implementation efforts related to systems development are unsuccessful, we may need to write off amounts that we have capitalized related to systems development projects. Additionally, if systems development implementations do not occur, we may need to incur additional costs to support our existing systems.

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

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

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

Beginning in 2009, we outsourced certain billing, collections and other administrative and clerical services to Intelenet and certain information systems functions to Perot Systems Corporation (now Dell Services), both of which perform many of these services outside of the United States. Operations in other parts of the world involve certain regional geopolitical risks that are different than operating in the United States, including the possibility of civil unrest, terrorism and substantial regulation by the individual governments. In addition, federal and state regulators have expressed concerns regarding the impact of offshoring on American

Table of Contents

business in general, including, for example, job loss, security and privacy concerns. During 2010, we experienced negative reactions from federal and state regulators, payors, patients and referral sources as a result of the actual or perceived concerns caused by the outsourcing of portions of our business operations related to certain billing, collections and other administrative and clerical services and we experienced increases in accounts receivable, reserves, write-offs of accounts receivable and loss of revenues. Accordingly, we determined to return certain of these outsourced functions to our personnel in the United States. This transition resulted in various one-time costs and operational inefficiencies that impacted our results in 2011 and 2012.

Our Failure to Maintain Required Licenses Could Impact Our Operations.

We are required to maintain a significant number of state and/or federal licenses for our operations and facilities. Certain employees primarily those with clinical expertise in pharmacy, nursing, respiratory therapy and nutrition are required to maintain licenses in the states in which they practice. We manage the facility licensing function centrally. In addition, individual clinical employees are responsible for obtaining, maintaining and renewing their professional licenses and we also have processes in place designed to notify branch or pharmacy managers of renewal dates for the clinical employees under their supervision. State and federal licensing requirements are complex and often open to subjective interpretation by various regulatory agencies. Accurate licensure is also a critical threshold issue for the Medicare competitive bidding program. From time to time, we may also become subject to new or different licensing requirements due to legislative or regulatory requirements developments or changes in our business, and such developments may cause us to make further changes in our business, the results of which may be material. Although we believe we have appropriate systems in place to monitor licensure, violations of licensing requirements may occur and our failure to acquire or maintain appropriate licensure for our operations, facilities and clinicians could result in interruptions in our operations, refunds to state and/or federal payors, sanctions or fines or the inability to serve Medicare beneficiaries in competitive bidding markets which could have an adverse material impact on our business, financial condition, results of operation, cash flow, capital resources and liquidity.

Our Failure to Maintain Accreditation Could Impact Our Operations.

Accreditation is required by most of our managed care payors and became a mandatory requirement for all Medicare DMEPOS providers effective October 1, 2009. In June 2010, we completed a nationwide independent triennial accreditation renewal process conducted by The Joint Commission, and the Commission renewed our accreditation for another three years. The Company is currently undergoing the next triennial survey cycle and expects to complete the cycle by June 1, 2013 resulting in a renewal for another three years. The Joint Commission accreditation encompasses our full complement of services including home health, home medical equipment, clinical respiratory, ambulatory infusion services, pharmacy dispensing, and clinical consultant pharmacist services. We have more than 24 years of continuous accreditation by The Joint Commission longer than any other homecare provider. If we or any of our branches lose accreditation, or if any of our new branches are unable to become accredited, our failure to maintain accreditation or become accredited could have a material adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

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

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

The Budget Control Act of 2011 authorized increases in the United State s debt limit of at least $2.1 trillion, established caps on funding appropriations estimated to reduce federal spending by $917 billion over the next ten years, and created the Joint Committee, a bipartisan committee consisting of twelve Members of Congress instructed to develop legislation to reduce the federal deficit by at least another $1.5 trillion over the ten-year period of fiscal years 2012 2021. Because Congress and the President failed to enact legislation reducing the deficit by at least $1.2 trillion over the ten-year period of fiscal years 2012 2021 by the January 15, 2012 deadline, automatic spending reductions in fiscal years 2013 2021 through sequestration, the required cancellation of budgetary resources, has been triggered. Under sequestration, certain federal programs are protected, including Medicaid. However, effective

61

Table of Contents

April 1, 2013, sequestration has caused payments to Medicare providers and suppliers to be reduced by 2%. It is unclear how long these reductions will be in effect. These reductions, along with any further reductions in provider and supplier reimbursement rates under federal healthcare programs, could have a material adverse effect on our financial condition and results of operations.

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

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

Our strategic growth plan may involve acquisition of other companies, such as our 2007 acquisition of Coram and our March 2011 acquisition of the assets of Praxair Healthcare Services home healthcare services division in the United States. Such acquisitions involve a number of risks, including:

- difficulties related to combining previously separate businesses into a single unit, including patient transitions, product and service offerings, distribution and operational capabilities and business cultures;
- availability of financing to the extent needed to fund acquisitions;
- customer loss and other general business disruption;
- managing the integration process while completing other independent acquisitions or dispositions;
- diversion of management s attention from day-to-day operations;
- assumption of liabilities of an acquired business, including unforeseen or contingent liabilities or liabilities in excess of the amounts estimated;
- failure to realize anticipated benefits and synergies, such as cost savings and revenue enhancements;
- potentially substantial costs and expenses associated with acquisitions and dispositions;
- failure to retain and motivate key employees;

difficulties in applying our internal control over financial reporting and disclosure controls and procedures to an acquired business;

obtaining necessary regulatory licenses and payor-specific approvals, which may impact the timing of when we are able to bill and collect for services rendered;

our ability to transition patients in a timely manner may impact our ability to collect amounts for services rendered;

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

The home respiratory/home medical equipment and home infusion therapy markets are highly competitive and include a large number of providers, some of which are national providers, but most of which are either regional or local providers, including hospital systems, physician specialists and sleep labs. We believe that the primary competitive factors are quality considerations such as responsiveness, the technical ability of the professional staff and the ability to provide comprehensive services. These markets are very fragmented. Some of our competitors may now or in the future have greater financial or marketing resources than we do. In addition, in certain markets, competitors may have more effective sales and marketing activities. Our largest national home respiratory/home medical equipment provider competitors are American HomePatient, Inc., Lincare Holdings, Inc. and Rotech Healthcare Inc. Our largest competitors in the home infusion therapy service market are Walgreens Home Care, Medco/Express Scripts and Bioscript. The rest of the homecare market in the United States consists of several medium-size competitors, as well as numerous small (under $3.5 million in annual revenues) local operations. There are relatively few barriers to entry in local home healthcare markets. Hospitals and health systems are routinely seeking to provide coverage and better control of post acute healthcare services, including homecare services of the types we provide. These trends may continue as new payment models evolve, including bundled payment models, shared savings programs, value based purchasing and other payment systems. For example, the Reform Package introduced various new payment and delivery system models, including Accountable Care Organizations (ACOs). ACOs can share in savings, assuming certain quality metrics are met or exceeded. The shared savings feature in ACOs causes them to reduce the amount of services they refer to us. ACOs may be formed by a variety of providers and/or suppliers, including hospitals and health systems, as well as home respiratory, home medical equipment and home infusion therapy service providers. Although participation in an ACO is voluntary, participation by our competitors in an ACO in certain markets may force us to participate as well or face a loss of business from ACO participants who are unwilling to refer to non-ACO participants. Even when we do participate, we may lose business if we do not meet the quality metrics that ACOs must earn to share in any savings they achieve. Moreover, commensurate with the formation of an ACO, physicians and/or hospitals may decide to provide home healthcare services through a newly developed capacity owned and/or controlled by themselves in a vertically integrated model. Similar programs may be adopted by other governmental, state and commercial payors, and we cannot predict the impact, if any, of such new models on our business. In addition, some managed care payors are developing their own pharmacy benefit managers (PBMs) or are expanding their contractual relationships with PBMs, and those PBMs then expand their scope of services into new areas such as specialty infusion and compete with us. We cannot assure you that these and other industry changes and the competitive nature of the homecare environment will not adversely affect our revenues and our business.

Table of Contents

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

The success of our business depends upon our ability to attract and retain highly motivated, well-qualified management and other employees. One of our largest costs is in the payment of salaries and benefits to our approximately 13,200 employees. We face significant competition in the recruitment of qualified employees, which has caused increased salary and wage rates among certain employee groups. If we are unable to recruit or retain a sufficient number of qualified employees, or if the costs of compensation or employee benefits increase substantially, our ability to deliver services effectively could suffer and our profitability would likely be adversely affected. The Reform Package may materially increase our cost of providing health benefits to our employees and their dependents. In addition, union organizing activities have occurred in the past and may occur in the future, and the adverse impact of unionization and organizing activities on our costs and operating results could be substantial.

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

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

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

We currently rely on a relatively small number of suppliers to provide us with the majority of our patient service equipment, pharmaceuticals and supplies. Many pharmaceuticals we procure have supply limitations and are subject to supply disruptions. Our inability to procure certain pharmaceuticals including maintaining and renewing certain agreements and access arrangements could have a materially adverse effect on our results of operations. We often use pharmaceutical and other suppliers selectively for quality and cost reasons. If we select against a certain pharmaceutical manufacturer or supplier we may still be dependent on them for some products. However we face a risk that they would terminate or raise prices where we are dependent on them. Significant price increases, or disruptions in the ability to obtain such equipment, pharmaceuticals and supplies from existing suppliers, may force us to use alternative suppliers. Additionally, the Reform Package calls for significant new excise taxes to be imposed on manufacturers of certain medical equipment and pharmaceuticals taxes which they could attempt to pass on to customers such as us. However, new legislation aimed at repealing the medical device excise tax, the Protect Medical Innovation Act of 2013 , was introduced in the House in February 2013 and has been referred to the House Ways and Means Committee. Such manufacturers may be forced to make other changes to their products or manufacturing processes that are unacceptable to us, resulting in our desire to change suppliers. Any change in suppliers we use could cause delays in the delivery of such products and possible losses in revenue, which could adversely affect our results of operations. In addition, alternative suppliers may not be available, or may not provide their products and services at similar or favorable prices. If we cannot obtain the patient service equipment, pharmaceuticals and supplies we currently use, or alternatives at similar or favorable prices, our ability to provide such products may be severely impacted, which could have an adverse effect on our business, financial condition, results of operations, cash flow, capital resources and liquidity.

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

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

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

We evaluate changes in home medical equipment technology and treatments on an ongoing basis for purposes of determining the feasibility of replacing or supplementing items currently included in the patient service equipment inventory and services that we offer our customers. The selection of medical equipment and services we offer is formulated on the basis of a variety of factors, including overall quality, functional reliability, availability of supply, payor reimbursement policies, product features, labor costs associated with the technology, acquisition, repair and ownership costs and overall patient and referral source demand, as well as patient therapeutic and lifestyle benefits. Manufacturers continue to invest in research and development to introduce new products to

64

Table of Contents

the marketplace. It is possible that major changes in available technology, payor benefit or coverage policies related to those changes, or the preferences of patients and referral sources may cause our current product offerings to become less competitive or obsolete, and it will be necessary for us to adapt to those changes. Unanticipated changes could cause us to incur increased capital expenditures and accelerated equipment write-offs, and could force us to alter our sales, operations and marketing strategies.

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

Our operations are subject to the many hazards inherent in the transportation of medical gas products and compressed and liquid oxygen, including ruptures, leaks and fires. These risks could result in substantial losses due to personal injury or loss of life, severe damage to and destruction of property and equipment and pollution or other environmental damage and may result in curtailment or suspension of our related operations. If a significant accident or event occurs, it could adversely affect our business, financial position and results of operations. Additionally, corrective action plans, fines or other sanctions may be levied by government regulators who oversee transportation of hazardous materials such as compressed or liquid oxygen.

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

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

We Previously Identified a Material Weakness in Our Internal Controls Over Financial Reporting. If We Do Not Maintain Effective Internal Controls Over Financial Reporting, We Could Fail to Accurately Report Our Financial Results.

In our Annual Report on Form 10-K for the fiscal year ended December 31, 2012, we disclosed that management had identified a material weakness in our internal control over financial reporting as of December 31, 2012. A material weakness is defined by the standards issued by the Public Company Accounting Oversight Board as a deficiency or a combination of deficiencies in internal control over financial reporting such that there is reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected. We did not effectively design and perform control activities to prevent or detect material misstatements that might exist in our presentation of cash receipts from the sale of patient service equipment on the consolidated statement of cash flows. In light of this material weakness in internal control over financial reporting, we also concluded that our disclosure controls and procedures were not effective as of December 31, 2012.

Subsequent to December 31, 2012, we have taken steps to remediate the material weakness described above. While we believe these steps have improved the effectiveness of our internal control over financial reporting and have remediated the material weakness, if our remediation efforts are insufficient to address the material weakness, or if additional material weaknesses in our internal controls are discovered in the future, they may adversely affect our ability to record, process, summarize and report financial information timely and accurately and, as a result, our financial statements may contain material misstatements or omissions.

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

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

65

Table of Contents

our indebtedness, materially affect the market price and trading liquidity of the Notes, and otherwise materially adversely affect our business and financial condition.

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

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

In connection with the impairment testing in the year ended December 31, 2011 and in the year ended December 31, 2012, we recorded non-cash impairment charges totaling $1,007.9 million, of which $657.9 million related to the year ended December 31, 2011 and $350.0 million related to the year ended December 31, 2012.

Non-cash impairment charge incurred in the year ended December 31, 2012 consisted of the following components:

(i) Trade name impairment of $350.0 million, $270.0 million of which relates to the home respiratory therapy/home medical equipment reporting unit and $80.0 million is allocated to the home infusion therapy reporting unit.

Non-cash impairment charges of $657.9 million incurred in the year ended December 31, 2011 are as follows:

(i) Goodwill impairment of $509.9 million;

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

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

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

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

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

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

Investment funds affiliated with the Sponsor collectively own a substantial majority of our capital stock, and the Sponsor designees hold a majority of the seats on our board of directors. As a result, affiliates of the Sponsor have control over our decisions to enter into any corporate transaction and have the ability to prevent any transaction that requires the approval of stockholders regardless of whether holders of our Notes believe that any such transactions are in their own best interests. For example, affiliates of the Sponsor could collectively cause us to make acquisitions that increase the amount of our indebtedness or to sell assets, or could cause us to issue additional capital stock or declare dividends. So long as investment funds affiliated with the Sponsor continue to indirectly own a significant amount of the outstanding shares of our common stock, affiliates of the Sponsor will continue to be able to strongly influence or effectively control our decisions. The indenture governing the Notes and the credit agreement governing our ABL Facility permit us to pay advisory and other fees, dividends and make other restricted payments to the Sponsor under certain circumstances and the Sponsor or its affiliates may have an interest in our doing so. In addition, the

Sponsor has no obligation to provide us with any additional debt or equity financing.

Table of Contents

Additionally, the Sponsor is in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us or that supply us with goods and services. For example, until recently affiliates of the Sponsor controlled Intelenet, an Indian company with which we contracted in 2009 to assist us with the outsourcing of certain revenue management functions. In July 2011, an affiliate of the Sponsor, along with other shareholders of Intelenet, sold Intelenet to Serco Group PLC, an international services company. The affiliate of the Sponsor may receive additional payments based on Intelenet s performance through 2013. The Sponsor may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. The holders of the Notes should consider that the interests of the Sponsor and other members of the Investor Group may differ from their interests in material respects.

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

For over a decade, we implemented a contractual business model with a number of hospitals which facilitates continuity of care and quality for patients who are being discharged from those hospitals to the homecare setting. We discontinued most of these arrangements in 2009. In these cases, we attempt to continue working closely with the hospitals to accept discharges for their patients who require our services. However, the dissolution of a contractual relationship may result in the decision by hospitals to refer patients to our competitors in lieu of or in addition to us. In addition, some hospitals are expanding the scope and geographic coverage of their existing home infusion and durable medical equipment businesses, or establishing new such affiliates, with the result that they refer their discharged patients to these affiliated home healthcare businesses and reduce their referrals to other providers like us. We are not able to predict whether the discontinuance of any additional hospital arrangements or the increasing competition from hospitals will have a material impact on our overall operational and financial results.

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

From time to time, our payor contracts are amended (sometimes by unilateral action by payors regarding payment policy), renegotiated, subjected to a bidding process with our competitors, or terminated altogether. Sometimes in the renegotiation process, certain lines of business may not be renewed or a payor may enlarge its provider network or otherwise adversely change the way it conducts its business with us. In other cases, a payor may reduce its provider network in exchange for lower payment rates. Our revenue from a payor may also be adversely affected if the payor alters its utilization management expectations and/or administrative procedures for payments and audits, changes its order of preference among the providers to which it refers business or imposes a third party administrator, network manager or other intermediary. Any reduction in our projected home respiratory therapy/home medical equipment reporting unit revenues as a result of these or other factors could lead to a further impairment of the value of our intangible assets which would result in a further decrease in these assets on our balance sheet. We cannot assure you that we will not have another such impairment charge or that our payor contracts will not be terminated or altered in ways that are unfavorable to us as a result of renegotiation or such administrative changes. Payors may decide to refer business to their owned provider subsidiaries such as for specialty pharmaceuticals and/or their owned pharmacy benefit managers or specialty benefit management companies. Some payors have developed or acquired an ownership interest in our competitors or administrative intermediaries. These activities could materially reduce our revenue from these payors.

Risks Relating to Our Indebtedness

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

We have a substantial amount of debt, which requires significant interest and principal payments. As of March 31, 2013, we had approximately $1,029.6 million of total debt outstanding. Subject to the limits contained in the credit agreement governing our ABL Facility, the indenture governing the Notes and our other debt instruments, we may be able to incur substantial additional debt from time to time to finance working capital, capital expenditures, investments or acquisitions, or for other purposes. If we do so, the risks related to our high level of debt could intensify. Specifically, our high level of debt could have important consequences, including the following:

making it more difficult for us to satisfy our obligations with respect to our debt;

limiting our ability to obtain additional financing to fund future working capital, capital expenditures, acquisitions or other general corporate requirements;

requiring a substantial portion of our cash flows to be dedicated to debt service payments instead of other purposes, thereby reducing the amount of cash flows available for working capital, capital expenditures, acquisitions and other general corporate purposes;

increasing our vulnerability to general adverse economic and industry conditions;

Table of Contents

exposing us to the risk of increased interest rates as certain of our borrowings may be at variable rates of interest;

limiting our flexibility in planning for and reacting to changes in the industry in which we compete;

placing us at a disadvantage compared to other, less leveraged competitors; and

increasing our cost of borrowing.

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

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

We May Be Unable to Service Our Indebtedness.

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

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

incur additional indebtedness or enter into sale and leaseback obligations;

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

make certain capital expenditures;

make certain loans, investments or other restricted payments;

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

engage in transactions with stockholders or affiliates;

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

amend or otherwise alter the terms of our indebtedness;

alter the business that we conduct;

guarantee indebtedness or incur other contingent obligations; and

create liens.

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

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

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

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

If there were an event of default under any of the agreements relating to our outstanding indebtedness, the holders of the defaulted debt could cause all amounts outstanding with respect to that debt to be due and payable immediately. We cannot assure you

Table of Contents

that our assets or cash flow would be sufficient to fully repay borrowings under our outstanding debt instruments if accelerated upon an event of default. Further, if we are unable to repay, refinance or restructure our indebtedness under our secured debt, the holders of such debt could proceed against the collateral securing that indebtedness. In addition, any event of default or declaration of acceleration under one debt instrument could also result in an event of default under one or more of our other debt instruments.

Under the terms of our ABL Facility, loans outstanding under the ABL Facility may be accelerated if any Series A-2 Notes remain outstanding on or after August 1, 2014. In addition, under the terms of our new senior secured credit agreement, outstanding loans thereunder may be similarly accelerated if more than $75.0 million of the Series A-2 Notes remain outstanding on or after September 2, 2014. If we are unable to repay or refinance the necessary amount of outstanding Series A-2 Notes prior to such dates, it may result in an acceleration of outstanding indebtedness under our ABL Facility and/or our new senior secured credit agreement, which may have a material adverse effect on our business, liquidity or financial condition.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

None.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

ITEM 5. OTHER INFORMATION

None.

Table of Contents

ITEM 6. EXHIBITS

Exhibits

3.1	Second Amended and Restated Certificate of Incorporation of Apria Healthcare Group Inc., incorporated by reference from Exhibit 3.1 to the registrant s Registration Statement on Form S-4 (File No. 333-168159).
3.2	Amended and Restated Bylaws of Apria Healthcare Group Inc. Incorporated by reference to Exhibit 3.2 to the registrant s Registration Statement on Form S-4 (File No. 333-168159).
10.1	Revised Compensation Agreement, dated as of February 19, 2013, between Peter A. Reynolds and Apria Healthcare Group Inc., incorporated by reference from Exhibit 10.40 to the registrant s Annual Report on Form 10-K for the year ended December 31, 2012 filed on March 11, 2013.
31.1*	Certification (pursuant to Securities Exchange Act Rule 13a-14(a)/15d-14(a) by Chief Executive Officer.
31.2*	Certification (pursuant to Securities Exchange Act Rule 13a-14(a)/15d-14(a) by Principal Financial Officer.
32.1**	Section 1350 Certification (pursuant to Section 906 of the Sarbanes-Oxley Act of 2002) by Chief Executive Officer.
32.2**	Section 1350 Certification (pursuant to Section 906 of the Sarbanes-Oxley Act of 2002) by Principal Financial Officer.
99.1*	Section 13(r) Disclosure
101*	The following materials from Apria Healthcare Group Inc. s Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, filed on May 1, 2013, formatted in XBRL (eXtensible Business Reporting Language): (i) Condensed Consolidated Balance Sheets, (ii) Condensed Consolidated Statements of Operations, (iii) Condensed Consolidated Statements of Cash Flows and (iv) Notes to Condensed Consolidated Financial Statements.

* Filed herewith
** Furnished herewith

Table of Contents

SIGNATURES

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

APRIA HEALTHCARE GROUP INC.

Date: May 1, 2013

By: /s/ JOHN G. FIGUEROA
John G. Figueroa
Chairman of the Board of Directors

and Chief Executive Officer

Date: May 1, 2013

By: /s/ PETER A. REYNOLDS
Peter A. Reynolds
Principal Financial Officer

and Chief Accounting Officer