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**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549**

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**FORM 10-Q**

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

**For The Quarterly Period Ended September 30, 2007**

**Commission File Number 000-50940**

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**ROTECH HEALTHCARE INC.**

(Exact Name of Registrant as Specified in Its Charter)

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**Delaware**  
(State or Other Jurisdiction of  
Incorporation or Organization)

**030408870**  
(IRS Employer  
Identification No.)

**2600 Technology Drive, Suite 300, Orlando, Florida**  
(Address of Principal Executive Offices)

**32804**  
(Zip Code)

**(407) 822-4600**  
(Registrant's Telephone Number, Including Area Code)

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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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large Accelerated Filer  Accelerated Filer  Non-Accelerated Filer

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

As of November 1, 2007, the registrant had 25,505,270 shares of common stock outstanding.

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**PART I—FINANCIAL INFORMATION**

**ITEM 1—Condensed Consolidated Financial Statements**

**ROTECH HEALTHCARE INC. AND SUBSIDIARIES**  
**UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS**  
(In thousands, except share data)

	<u>September 30,</u> <u>2007</u>	<u>December 31,</u> <u>2006</u>
<b>Assets</b>		
Current assets:		
Cash and cash equivalents	\$ 67,876	\$ 10,265
Accounts receivable, net	76,446	78,692
Other accounts receivable	2,587	1,114
Income taxes receivable	1,805	—
Inventories	9,942	9,486
Prepaid expenses	3,786	4,624
Total current assets	162,442	104,181
Property and equipment, net	140,325	148,153
Intangible assets (less accumulated amortization of \$7,495 at September 30, 2007 and \$6,121 at December 31, 2006)	18,650	19,904
Other goodwill	43,876	43,876
Reorganization value in excess of fair value of identifiable assets—goodwill	163,154	163,154
Deferred tax asset, net	10,756	4,803
Restricted cash	13,343	—
Other assets	15,151	13,062
	<u>\$ 567,697</u>	<u>\$ 497,133</u>
<b>Liabilities and Stockholders' Equity</b>		
Current liabilities:		
Accounts payable	\$ 23,686	\$ 22,124
Accrued expenses and other current liabilities, including dividends payable	18,121	19,213
Accrued interest	17,288	7,194
Deferred revenue	10,686	10,330
Deferred tax liabilities, net	11,931	8,172
Income taxes payable	—	1,225
Current portion of long-term debt	110	4,053
Total current liabilities	81,822	72,311
Priority tax claim	1,369	2,313
Other long-term liabilities	910	636
Long-term debt, less current portion	474,177	380,813
Series A convertible redeemable preferred stock, stated value \$20 per share, 1,000,000 shares authorized, 245,537 and 246,508 shares issued and outstanding at September 30, 2007 and December 31, 2006, respectively	5,230	5,343
Stockholders' equity:		
Common stock, par value \$.0001 per share 50,000,000 shares authorized, 25,505,270 shares issued and outstanding at September 30, 2007 and 25,481,270 shares issued and outstanding at December 31, 2006	3	3
Additional paid-in capital	505,517	505,310
Accumulated deficit	(501,331)	(469,596)
Total stockholders' equity	4,189	35,717
	<u>\$ 567,697</u>	<u>\$ 497,133</u>

See accompanying notes to unaudited condensed consolidated financial statements.

**ROTECH HEALTHCARE INC. AND SUBSIDIARIES**  
**UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
(In thousands, except share and per share data)

	Three months ended September 30,		Nine months ended September 30,	
	2007	2006	2007	2006
Net revenues	\$ 140,933	\$ 127,218	\$ 420,624	\$ 371,537
Cost of net revenues:				
Product and supply costs	33,605	24,525	107,903	73,530
Patient service equipment depreciation	12,283	11,202	35,921	33,532
Operating costs	6,252	5,757	18,113	18,332
Total cost of net revenues	52,140	41,484	161,937	125,394
Provision for doubtful accounts	5,163	3,464	13,748	10,900
Selling, general and administrative	73,050	71,664	224,021	225,273
Depreciation and amortization	3,511	3,948	10,898	13,039
Goodwill impairment	—	80,000	—	529,000
Total costs and expenses	133,864	200,560	410,604	903,606
Operating income (loss)	7,069	(73,342)	10,020	(532,069)
Interest expense, net	12,099	9,544	34,194	26,687
Other income, net	(385)	(203)	(337)	(127)
Loss on extinguishment of debt	—	1,212	12,171	1,212
Loss before income taxes	(4,645)	(83,895)	(36,008)	(559,841)
Federal and state income tax benefit	(1,583)	—	(4,611)	(42,290)
Net loss	(3,062)	(83,895)	(31,397)	(517,551)
Accrued dividends on redeemable preferred stock	113	113	338	338
Net loss attributable to common stockholders	\$ (3,175)	\$ (84,008)	\$ (31,735)	\$ (517,889)
Net loss per common share—basic	\$ (0.12)	\$ (3.30)	\$ (1.24)	\$ (20.35)
Net loss per common share—diluted	\$ (0.12)	\$ (3.30)	\$ (1.24)	\$ (20.35)
Weighted average shares outstanding—basic	25,505,270	25,481,270	25,499,556	25,454,750
Weighted average shares outstanding—diluted	25,505,270	25,481,270	25,499,556	25,454,750

See accompanying notes to unaudited condensed consolidated financial statements.

**ROTECH HEALTHCARE INC. AND SUBSIDIARIES**  
**UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(In thousands)

	Nine months ended September 30,	
	2007	2006
Net loss	\$ (31,397)	\$ (517,551)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Provision for doubtful accounts	13,748	10,900
Depreciation and amortization	48,990	48,014
Loss on extinguishment of debt	12,171	1,212
Deferred income taxes	(2,195)	(42,290)
Goodwill impairment	—	529,000
Other reconciling adjustments	240	387
Changes in operating assets and liabilities:		
Accounts receivable	(11,502)	(17,727)
Other receivables	(1,473)	(479)
Income taxes receivable	(1,805)	—
Inventories	(456)	(78)
Prepaid expenses	838	657
Other assets	(48)	(462)
Accounts payable and accrued expenses	1,962	(1,826)
Other long-term liabilities	275	(41)
Accrued interest	17,068	(6,428)
Income taxes payable	(1,225)	(462)
Deferred revenue	356	1,184
Net cash provided by operating activities	<u>45,547</u>	<u>4,010</u>
Cash flows from investing activities:		
Purchases of property and equipment	(37,497)	(46,825)
Business acquisitions	—	(1,816)
Increase in restricted cash	(13,343)	—
Net cash used in investing activities	<u>(50,840)</u>	<u>(48,641)</u>
Cash flows from financing activities:		
Proceeds from short-term borrowings	7,000	59,300
Payments of short-term borrowings	(8,500)	(62,787)
Payments of long-term borrowings	(238)	(219)
Retirement of long-term borrowings	(94,525)	(42,013)
Proceeds from long-term borrowings	180,000	95,000
Debt issuance costs	(8,013)	(5,158)
Prepayment premium on long term borrowings	(8,367)	—
Proceeds from short-swing profits	18	—
Payments of dividends on preferred stock	(450)	—
Principal payments on capital leases	(3,138)	(139)
Changes in liabilities subject to compromise/priority tax claim	(883)	(689)
Net cash provided by financing activities	<u>62,904</u>	<u>43,295</u>
Increase (decrease) in cash and cash equivalents	57,611	(1,336)
Cash and cash equivalents, beginning of period	<u>10,265</u>	<u>14,222</u>
Cash and cash equivalents, end of period	<u>\$ 67,876</u>	<u>\$ 12,886</u>

See accompanying notes to unaudited condensed consolidated financial statements.

**ROTECH HEALTHCARE INC. AND SUBSIDIARIES**  
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
**(Unaudited)**  
**(In thousands, except share and per share data)**

**(1) Basis of Presentation**

The accompanying unaudited condensed consolidated financial statements include the accounts of Rotech Healthcare Inc. and its subsidiaries and have been prepared in accordance with generally accepted accounting principles for interim financial information and with the instructions to Form 10-Q. 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. Interim results are not necessarily indicative of results to be expected for the full year. The preparation of financial statements in conformity with generally accepted accounting principles in the United States of America requires management to make assumptions that affect the amounts reported in the financial statements and accompanying notes. In general, management's estimates are based upon historical experience, information from third party professionals and various other assumptions that we believe to be reasonable under the facts and circumstances. Actual results could differ from those estimates made by management. For further information, refer to the consolidated financial statements and notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2006. Certain reclassifications have been made to prior period amounts to conform to the current period presentation.

As used in these notes, unless otherwise specified or the context otherwise requires, references to "the Company", "we", "our" and "us" refer to the business and operations of Rotech Healthcare Inc. and its subsidiaries.

For all periods presented herein, there were no differences between net income and comprehensive income.

**(2) Recent Accounting Pronouncements**

In June 2006, the FASB issued Interpretation No. 48, *Accounting for Uncertainty in Income Taxes, an interpretation of FASB Statement 109* (FIN 48). This statement clarifies the criteria that an individual tax position must satisfy for some or all of the benefits of that position to be recognized in a company's financial statements. FIN 48 prescribes a recognition threshold of more-likely-than-not, and a measurement attribute for all tax positions taken or expected to be taken on a tax return, in order for those tax positions to be recognized in the financial statements. Effective January 1, 2007, we adopted the provisions of FIN 48 and there was no material effect on our financial statements. As a result, there was no cumulative effect related to the adoption of FIN 48. However, certain amounts have been reclassified in the accompanying consolidated balance sheet in order to comply with the requirements of FIN 48. See Note 11 for additional information regarding FIN 48.

**(3) Liquidity and Debt Refinancing**

On March 30, 2007, we entered into a credit agreement (the "Credit Agreement") with the lenders that are parties thereto (the "Lenders"). Pursuant to the Credit Agreement, the Lenders have provided a payment-in-kind term loan facility in an aggregate principal amount of \$180,000 (the "Senior Facility"). We used the proceeds of the Senior Facility to (i) repay all amounts due under our former credit agreement dated as of September 15, 2006 and terminated such agreement in connection therewith, (ii) pay associated transaction costs, and (iii) cash collateralize our existing letters of credit. We expect to use the balance of the loan for general working capital purposes. The Senior Facility is scheduled to mature on September 26, 2011 and the obligations thereunder are secured by substantially all of our assets and the assets of our subsidiaries. The interest rate under the Senior Facility is equal to the Base Rate plus 5% or the Eurodollar Rate plus 6%. The interest period, at our election, can be one, two, three or six months. Upon each renewable term we have the ability to change the interest period. See Note 10 for additional details regarding the terms of the Senior Facility.

**(4) Earnings Per Common Share**

Basic earnings per share (EPS) are computed by dividing earnings attributable to common stockholders by the weighted average number of common shares outstanding for the periods. Diluted EPS reflects the potential dilution of securities that could share in the earnings, including stock options and stock awards, and are based upon the weighted average number of common and common equivalent shares outstanding during the three months and nine months ended September 30, 2007 and 2006. Anti-dilutive weighted average common equivalent shares including anti-dilutive stock options and the Series A convertible redeemable preferred stock (Series A Preferred) on an "if converted" basis totaling 4,923,527 and 2,842,269 for the three months ended September 30, 2007 and 2006, respectively, and 3,727,204 and 2,990,827 for the nine months ended September 30, 2007 and 2006, respectively, are excluded from the computation of diluted EPS. We use the treasury stock method to compute the dilutive effects of common equivalent shares.

The reconciliations of net loss attributable to common stockholders and shares outstanding for purposes of calculating basic and diluted EPS for the three and nine months ended September 30, 2007 and 2006 are as follows:

	<u>Net Loss (Numerator)</u>	<u>Shares (Denominator)</u>	<u>Per Share Amount</u>
<b>For the Three Months Ended September 30, 2006:</b>			
Basic and diluted EPS:			
Net loss	\$ (83,895)		
Accrued dividends on redeemable preferred stock	113		
Net loss attributable to common stockholders	<u>\$ (84,008)</u>	<u>25,481,270</u>	<u>\$ (3.30)</u>
<b>For the Three Months Ended September 30, 2007:</b>			
Basic and diluted EPS:			
Net loss	\$ (3,062)		
Accrued dividends on redeemable preferred stock	113		
Net loss attributable to common stockholders	<u>\$ (3,175)</u>	<u>25,505,270</u>	<u>\$ (0.12)</u>
<b>For the Nine Months Ended September 30, 2006:</b>			
Basic and diluted EPS:			
Net loss	\$(517,551)		
Accrued dividends on redeemable preferred stock	338		
Net loss attributable to common stockholders	<u>\$(517,889)</u>	<u>25,454,270</u>	<u>\$ (20.35)</u>
<b>For the Nine Months Ended September 30, 2007:</b>			
Basic and diluted EPS:			
Net loss	\$ (31,397)		
Accrued dividends on redeemable preferred stock	338		
Net loss attributable to common stockholders	<u>\$ (31,735)</u>	<u>25,499,556</u>	<u>\$ (1.24)</u>

Each share of our Series A Preferred has a stated value of \$20 and entitles the holder to an annual cumulative dividend equal to 9% of its stated value, payable semi-annually at the discretion of our board of directors in cash or in additional shares of Series A Preferred. In the event dividends are declared by our board of directors but not paid for six consecutive periods, the holders of the Series A Preferred are entitled to vote as a separate class to elect one director to serve on our board of directors. Effective December 5, 2003, our board of directors adopted a policy of declaring dividends to the holders of the Series A Preferred under the Rotech Healthcare Inc. Employees Plan on an annual basis, with each such declaration to be made at the annual meeting of the board of directors with respect to dividends payable for the preceding year. At December 31, 2006 dividends in the amount of \$450 were included in our accompanying consolidated balance sheet within "Accrued expenses and other current liabilities, including dividends payable" which were subsequently paid in January 2007. At the 2007 annual meeting of the board of directors held on June 29, 2007, dividends in the amount of \$450 were declared on our Series A Preferred. Such dividends are included in our accompanying consolidated balance sheet as of September 30, 2007 within "Accrued expenses and other current liabilities, including dividends payable."

## (5) Acquisitions

We made no acquisitions during the nine month period ended September 30, 2007. During the nine month period ended September 30, 2006, we acquired businesses with a total aggregate cost of \$2,644.

Our acquisitions are accounted for using the purchase method of accounting. The results of operations are included in the condensed consolidated financial statements from the purchase date. We allocated the purchase price related to our business acquisition activities during the nine month period ended September 30, 2006 to the following assets:

Property and equipment	\$ 339
Intangible assets	699
Goodwill	<u>1,606</u>
Total assets acquired	<u>\$2,644</u>

Pro forma results of operations reflecting the 2006 acquisition activity as if it had occurred at the beginning of the nine month period ended September 30, 2006 have not been presented since the amounts are immaterial to us.

As of December 31, 2006, we had \$1,500 of deferred acquisition obligations included in our accompanying consolidated balance sheet within accrued expenses and other current liabilities. During the nine month period ended September 30, 2007, we paid the full remaining balance of these obligations as they came due and we have no remaining deferred acquisition obligations as of September 30, 2007.

**(6) Goodwill and Other Intangible Assets**

Our branch locations have similar economic characteristics and are aggregated into one reporting unit for impairment testing purposes. Management performs the required annual impairment test during the fourth quarter, or more frequently, if required. Goodwill of a reporting unit will be tested for impairment between annual tests if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

The following table reflects the components of other identifiable intangible assets:

	September 30, 2007		December 31, 2006	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
<b>Intangible assets subject to amortization:</b>				
Customer/physician relationship	\$ 12,000	\$ 3,300	\$ 12,000	\$ 2,850
Computer software	5,000	1,833	5,000	1,583
Acquired customer lists, trade names and other	7,025	2,362	7,025	1,688
Subtotal	<u>24,025</u>	<u>7,495</u>	<u>24,025</u>	<u>6,121</u>
<b>Intangible assets not subject to amortization:</b>				
Trade name	1,120	—	1,000	—
Medicare licenses	1,000	—	1,000	—
Subtotal	<u>2,120</u>	<u>—</u>	<u>2,000</u>	<u>—</u>
Total intangible assets	<u>\$ 26,145</u>	<u>\$ 7,495</u>	<u>\$ 26,025</u>	<u>\$ 6,121</u>

Amortization expense for the three and nine months ended September 30, 2007 was approximately \$330 and \$1,374, respectively. Amortization expense for the three and nine months ended September 30, 2006 was approximately \$347 and \$1,037, respectively. As of September 30, 2007 and December 31, 2006, other goodwill was \$43,876.

Estimated amortization expense for each of the fiscal years ending December 31 is as follows:

	Amount
2007	\$1,707
2008	1,327
2009	1,325
2010	1,252
2011	1,181

**(7) Segment Data**

We operate in one reportable segment with three primary product lines: respiratory therapy equipment and services, durable medical equipment, and other health care products. The following table presents net revenues from distribution by each of our three primary product lines:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
Respiratory therapy equipment and services	\$125,043	\$111,265	\$373,190	\$325,331
Durable medical equipment	14,693	14,780	43,954	42,858
Other health care products	1,197	1,173	3,480	3,348
Net revenue	<u>\$140,933</u>	<u>\$127,218</u>	<u>\$420,624</u>	<u>\$371,537</u>

**(8) Other Commitments and Contingencies**

We are subject to workers' compensation and employee health benefit claims, which are primarily self-insured. We do, however, maintain certain stop-loss and other insurance coverage which management believes to be appropriate.

Provisions for estimated settlements relating to workers' compensation are provided in the applicable period on a case-by-case basis. We review our estimated provisions on a quarterly basis and make changes when necessary. Differences between the amounts accrued and subsequent settlements are recorded in operations in the period of settlement. We estimate claim amounts incurred but not reported relating to health benefit plans in the applicable period and review such amounts on a quarterly basis.

We and our subsidiaries are parties to various legal proceedings in the ordinary course of business. For more information regarding our recent legal proceedings, see Note 9, "Certain Significant Risks and Uncertainties and Significant Events."

**(9) Certain Significant Risks and Uncertainties and Significant Events**

We and others in the health care business are subject to certain inherent risks, including the following:

- Substantial dependence on revenues derived from reimbursement by various federal health care programs (including Medicare) and state Medicaid programs which have been significantly reduced in recent years and which entail exposure to various health care fraud statutes;
- Inconsistent payment patterns from Centers for Medicare and Medicaid Services and its contractors and other third party payors;
- Government regulations, government budgetary constraints and proposed legislative, reimbursement and regulatory changes; and
- Lawsuits alleging malpractice and related claims.

Such inherent risks require the use of certain management estimates in the preparation of our financial statements and it is reasonably possible that changes in such estimates may occur.

We receive payment for a significant portion of services rendered to patients from the federal government under Medicare and other federally funded programs (including the Veterans Administration) and from the states under Medicaid. Revenue derived from Medicare, Medicaid and other federally funded programs represented 65.4% and 67.5% of our patient revenue for the three months ended September 30, 2007 and 2006, respectively, and 66.1% and 67.8% for the nine months ended September 30, 2007 and 2006, respectively.

Due to the nature of the business, we are involved in lawsuits that arise in the ordinary course of business. Management does not believe that any such lawsuits we (or our predecessor, Rotech Medical Corporation, the "Predecessor") are a party to, if resolved adversely, would have a material adverse effect on our financial condition or results of operations. We are also subject to malpractice and related claims, which arise in the normal course of business and which could have a significant effect on us. We maintain occurrence basis professional and general liability insurance with coverage and deductibles which we believe to be appropriate. In addition to lawsuits arising in the ordinary course of business, we are also subject to the following legal proceedings that, if resolved adversely, may have a material adverse effect on our financial condition, results of operations or liquidity.

As previously disclosed, on February 2, 2000, Integrated Health Services and substantially all of its subsidiaries, including the Predecessor filed voluntary petitions in the Bankruptcy Court under Chapter 11 of the United States Bankruptcy Code. By order of the Bankruptcy Court, the last day on which pre-bankruptcy claims could be filed, with certain exceptions, was August 29, 2000. Claims were asserted against the Predecessor with respect to various obligations. On February 13, 2002, the Bankruptcy Court confirmed the Predecessor's plan of reorganization (the "Plan") which became effective on March 26, 2002. On December 20, 2004, the Bankruptcy Court entered a final decree closing the Predecessor's bankruptcy case. In connection with its emergence from bankruptcy, claims made against the Predecessor prior to the date it filed for bankruptcy protection were satisfied in accordance with the terms of the Plan or pursuant to settlement agreements approved by the Bankruptcy Court. However, although management believes that all pre-petition state claims have also been discharged or dealt with in the Plan, states in other bankruptcy cases have challenged whether, as a matter of law, their claims could be discharged in a federal bankruptcy proceeding if they never made an appearance in the case. The issue has not been finally settled by the United States Supreme Court. Therefore, there is no assurance that a court would find that emergence from bankruptcy would discharge all such state claims against the Predecessor or the Company involving pre-petition claims. Since the date of confirmation of the Plan, neither the Company nor the Predecessor has received any correspondence from a state challenging the pre-petition discharge of claims.

On April 30, 2003, federal agents served search warrants at our corporate headquarters and four other facilities in three states and were provided access to a number of current and historical financial records and other materials. We have also received subpoenas on behalf of the United States Attorney's Office for the Northern District of Illinois relating to

the same subject matter including information relating to Medicare billing and VA contracting. We are cooperating fully with the investigation; however, we can give no assurances as to the duration of the investigation or as to whether or not the government will institute proceedings against us or any of our employees or as to the violations that may be asserted. In addition, we received informal requests for information on March 7, 2003 and April 17, 2003 from the Division of Enforcement of the Securities and Exchange Commission (the "SEC") related to matters that were the subject of our previously disclosed internal investigation regarding VA contracts and we have provided documents in response to such requests. We have not had any communications with the SEC regarding this matter since 2003. In addition, on August 25, 2005, we received a request for information and documents from the Division of Enforcement of the SEC related to our restatement of prior period financial results discussed in Note 21 to the consolidated financial statements included in our annual report on Form 10-K/A for the year ended December 31, 2004. On August 20, 2007, the Staff of the SEC's Division of Enforcement formally confirmed to us that the investigation in this matter has been completed and that the Staff would not recommend any enforcement action by the SEC with respect to the matter. In addition, on July 15, 2005, a qui tam complaint brought by one of our former employees was unsealed and served on us and several of our subsidiaries. The complaint, filed in Texas federal court, alleges violations of the False Claims Act for fraudulent billing practices. As of the date of this filing, the United States has declined to intervene in the action, although the United States has indicated that it may intervene if a mutually agreeable settlement is not reached. On September 1, 2005, we filed a motion to dismiss the complaint which remains pending. On March 6, 2006, the parties filed a joint motion to stay all activities in the case in order to engage in further discussions, which was granted. Additional motions have subsequently been filed and granted which extend the stay until November 30, 2007. In addition, on November 7, 2006, one of our subsidiaries, Rotherth's Hospital Equipment, Inc., received a subpoena from the Office of Inspector General for the Department of Health and Human Services. The subpoena requested documents relating to Medicare billing in the Covington, Kentucky, area between January 2003 and February 2004, as well as certain personnel records. We have produced the requested documents and we will continue to cooperate with the investigation.

As a health care provider, we are subject to extensive government regulation, including numerous laws directed at preventing fraud and abuse and laws regulating reimbursement under various government programs. The marketing, billing, documentation and other practices of health care companies are all subject to government scrutiny. To ensure compliance with Medicare and other regulations, regional carriers often conduct audits and request patient records and other documents to support claims submitted by us for payment of services rendered to patients. Similarly, government agencies periodically open investigations and obtain information from health care providers pursuant to legal process. Violations of federal and state regulations can result in severe criminal, civil and administrative penalties and sanctions, including disqualification from Medicare and other reimbursement programs.

Our predecessor, Rotech Medical Corporation, and the Office of Inspector General (the "OIG") of the DHHS entered into a Corporate Integrity Agreement as part of the process of settling the United States federal government's fraud claims against Rotech Medical Corporation in the aforementioned bankruptcy proceeding. As the successor to the business and operations of Rotech Medical Corporation, we are subject to the provisions of the Corporate Integrity Agreement. Providers and suppliers enter into corporate integrity agreements as part of settlements with the federal government in order that the federal government will waive its right to permissively exclude them from participating in federal health care programs. The term of the Corporate Integrity Agreement expired in February 2007; however, certain sections of the agreement (including, OIG inspection, audit and review rights and document retention obligations) will remain in effect until the OIG has completed its review of our final annual report and any additional materials submitted by us pursuant to OIG's request. We submitted our final annual report on June 28, 2007. If we were to be found in violation of any terms of the Corporate Integrity Agreement, we may be subject to substantial penalties, including stipulated cash penalties ranging from one thousand to two thousand five hundred dollars per day for each day we are in breach of the agreement, and, possibly, exclusion from federal health care programs.

## (10) Debt

Our long-term debt consists of the following:

	September 30, 2007	December 31, 2006
Capital lease obligation with interest implied at a fixed rate of 7.3%, due in equal monthly payments through June 2010, secured by equipment	\$ 313	\$ —
Capital lease obligation with interest implied at a fixed rate of 9.0%, due in two installments payable in 2007, secured by equipment	—	3,103
Former senior secured term loan under the former credit facility repaid in full on March 30, 2007	—	94,763
Current secured payment-in-kind term loan under current credit facility; due September 26, 2011, interest accrued at the Eurodollar Rate plus 6.0% and added to the principal amount of the loan on each interest payment date	186,974	—
Senior subordinated notes, due April 1, 2012, with interest at a fixed rate of 9.5% payable semi-annually on April 1 and October 1	287,000	287,000
Sub-total	474,287	384,866
Less current portion	110	4,053
Total long-term debt	<u>\$ 474,177</u>	<u>\$ 380,813</u>

As described in Note 3, we entered into a new credit agreement on March 30, 2007. Pursuant to such credit agreement, the lenders thereunder have provided a payment-in-kind term loan facility in an aggregate principal amount of \$180,000. We used the proceeds of the new senior credit facility to (i) repay all amounts due under our former credit agreement dated as of September 15, 2006 and terminated such agreement in connection therewith, (ii) pay associated transaction costs, and (iii) cash collateralize our existing letters of credit. We expect to use the balance of the loan for general working capital purposes. The new senior credit facility is scheduled to mature on September 26, 2011. The interest rate under the new credit agreement is equal to the Base Rate plus 5% or the Eurodollar Rate plus 6% (11.4% as of September 30, 2007). The interest period, at our election, can be one, two, three or six months. Upon each renewable term we have the ability to change the interest period. As a payment-in-kind term loan facility, accrued interest is added to the principal amount on each interest payment date, provided that we may, at our election, pay any such accrued interest in cash on such date. We have not elected to pay any such accrued interest in cash during the nine months ended September 30, 2007. Accordingly, during the three and nine months ended September 30, 2007, a total of \$5,219 and \$6,974, respectively, in accrued interest has been added to the principal amount on the applicable interest payment dates (representing all accrued interest under the payment-in-kind term loan that became payable during such periods), increasing the principal amount outstanding to \$186,974 as of September 30, 2007. As of September 30, 2007, we have \$3,608 in accrued interest on the payment-in-kind term loan. We incurred \$8,013 of deferred financing costs associated with the closing of the new credit agreement. Such costs are being amortized over the term of the loan under the effective interest method.

As a result of the termination of our former credit agreement dated September 15, 2006, we recorded a \$12,171 loss on extinguishment of debt during the nine months ended September 30, 2007 (all of which was recorded during the three months ended March 31, 2007) related to unamortized debt issuance costs of \$3,804 and prepayment premiums of \$8,367 associated with the former credit agreement.

The new credit agreement provides for mandatory prepayment upon the occurrence of certain specified events. The credit agreement contains customary covenants for financings of this type, including, but not limited to, limitations on dividends, limitations on redemptions and repurchases of, equity interests, limitations on prepayments of junior indebtedness, redemptions and repurchases of debt (other than loans under the senior facility), limitations on liens and sale-leaseback transactions, limitations on loans and investments, limitations on debt and guarantees, limitations on mergers, acquisitions and asset sales, limitations on transactions with affiliates, limitations on changes in business conducted by the Company and its subsidiaries, restrictions on ability of subsidiaries to pay dividends or make distributions, limitations on modifications of certain debt and debt instruments, and limitations on capital expenditures. The credit agreement also contains a financial covenant which requires us to maintain a specified minimum EBITDA threshold.

The credit agreement contains customary events of default. Such events of default include, but are not limited to: (i) the failure to pay principal or interest when due, (ii) the breach or failure to perform certain covenants or obligations and the failure to cure the same within a specified number of days, (iii) material breach of our representations and warranties, (iv) the occurrence of a change of control (as defined in the credit agreement), and (v) the commencement of any proceeding relating to bankruptcy by us or any guarantor. Under certain circumstances, if an event of default occurs and is continuing, payment of amounts due under the credit agreement may be accelerated.

In connection with the credit agreement, on March 30, 2007, we also entered into a Guarantee and Collateral Agreement, pursuant to which the obligations thereunder are guaranteed by substantially all of our domestic subsidiaries (the "Subsidiary Guarantors") and the obligations under the new senior facility are secured by substantially all of our assets and the assets of the Subsidiary Guarantors.

We have outstanding letters of credit totaling \$11,898 as of September 30, 2007, which are cash collateralized at 105% of their face amount. The cash collateral in the amount of \$12,493 is included in restricted cash in our accompanying consolidated balance sheet as of September 30, 2007.

Our senior subordinated notes are subordinated to our existing and future senior debt. Because the notes are subordinated, in the event of bankruptcy, liquidation or dissolution, or certain other events, including certain defaults on senior debt, we may be prevented from making payments on the subordinated notes. The indenture governing the senior subordinated notes contains covenants that, among other things, limit our ability to incur additional indebtedness and issue certain capital stock; pay dividends on, redeem or repurchase capital stock; make investments; sell assets; engage in transactions with affiliates; create certain liens; and consolidate, merge or transfer all or substantially all of our assets. The indenture also provides that a default under our credit agreement that results in the acceleration of our obligations under such agreement will create an event of default on our outstanding senior subordinated notes, which will allow the holders of at least 25% of the principal amount of the then outstanding senior subordinated notes to declare such notes immediately due and payable.

## **(11) Income Taxes**

We recorded a net tax benefit of \$1,583 for the three months ended September 30, 2007 and a net tax benefit of \$4,611 for the nine months ended September 30, 2007. The current period tax benefit is primarily the result of the expiration of various statutes of limitations and a favorable settlement of an appeal of state income taxes related to 2002. We have provided a full valuation allowance against our remaining net deferred tax assets as of September 30, 2007 because management's judgment is that it is more likely than not that the net deferred tax assets will not be realized, based on a number of factors, including the goodwill impairment charge recorded during 2006, future taxable income and the fact that the market in which we compete is competitive and characterized by changing reimbursement practices.

As of September 30, 2007, we have available federal net operating loss (NOL) carryforwards of approximately \$98,338 net of the de-recognition recorded as a result of the change in ownership interest under Section 382 of the Internal Revenue Code. These remaining NOLs fully expire in 2027. NOL carryforwards and credits are subject to review and possible other adjustments by the Internal Revenue Service and may be further limited by the occurrence of certain events, including other significant changes in ownership interests as was the case in 2006. The effect of an ownership change is the imposition of an annual limitation on the use of the NOL carryforwards attributable to periods before the change. The change in ownership interest under Section 382 of the Internal Revenue Code that occurred on December 31, 2006 resulted in the de-recognition of \$93,679 of NOL carryforwards.

We adopted the provisions of FIN 48 effective January 1, 2007, and there was no material effect on our financial statements. As a result, there was no cumulative effect related to adopting FIN 48. However, \$1,600 of current liabilities was reclassified to long-term liabilities in the accompanying consolidated balance sheet in order to comply with the requirements of FIN 48. As of January 1, 2007, we recorded a liability of \$1,600 for unrecognized tax benefits related to various federal and state income tax matters. If recognized, all of this amount would impact our effective tax rate. There is no difference between the total amount of unrecognized tax benefit and the amount that would impact the effective tax rate because no federal tax benefit of state income tax items would be recognized based on the current valuation of the deferred tax assets. The liability was decreased by \$468 for the three months ended September 30, 2007 and decreased by \$425 for the nine months ended September 30, 2007 due to the expiration of various statute of limitations. We do not expect that the amounts of unrecognized tax benefits will change significantly within the next 12 months.

We are currently open to tax adjustments under the statute of limitations by the Internal Revenue Service for the years ending December 31, 2004 through 2006. Our state income tax returns are open to tax adjustments under the various statutes of limitations for the years ending December 31, 2002 through 2006.

As of January 1, 2007, we accrued \$243 of interest related to uncertain tax positions. As of September 30, 2007, the total amount of accrued interest was \$172. We account for interest and penalties related to uncertain tax positions as part of our provision for federal and state income taxes.

## (12) Supplemental Cash Flow and Non-cash Investing and Financing Information

	For the nine months ended September 30,	
	2007	2006
Cash payments for:		
Interest	\$16,245	\$32,149
Income taxes	\$ 259	\$ 33
Non-cash investing activities:		
Purchases of property and equipment included in accounts payable	\$ 3,392	\$ 5,643
Deferred acquisition obligations	\$ —	\$ 300
Non-cash financing activities:		
Payment-in-kind interest added to principal	\$ 6,974	\$ —
Assets acquired under capital lease	\$ 348	\$ —

### ITEM 2—Management’s Discussion and Analysis of Financial Condition and Results of Operations

*The following discussion of our financial condition and results of operations should be read in conjunction with the condensed consolidated financial statements and the notes thereto included elsewhere in this Quarterly Report on Form 10-Q and our consolidated financial statements for the year ended December 31, 2006 and the notes thereto included in our Annual Report on Form 10-K previously filed with the Securities and Exchange Commission. As used herein, unless otherwise specified or the context otherwise requires, references to the “Company”, “we”, “our” and “us” refer to the business and operations of Rotech Healthcare Inc. and its subsidiaries.*

#### Overview

##### *Background*

We provide home medical equipment and related products and services in the United States, with a comprehensive offering of respiratory therapy and durable home medical equipment and related services. We provide equipment and services in 48 states through approximately 500 operating centers located primarily in non-urban markets.

Our revenues are principally derived from respiratory equipment rental and related services, which accounted for 88.7% and 87.5% of net revenues for the three months ended September 30, 2007 and 2006, respectively and 88.7% and 87.6% of net revenues for the nine months ended September 30, 2007 and 2006, respectively. Revenues from respiratory rental and related services include the rental of oxygen concentrators, liquid oxygen systems, portable oxygen systems, ventilator therapy systems, nebulizer equipment and sleep disorder breathing therapy systems, and the sale of nebulizer medications. We also generate revenues from the rental and sale of durable medical equipment accounting for 10.4% and 11.6% of net revenues for the three months ended September 30, 2007 and 2006, respectively and 10.4% and 11.5% of net revenues for the nine months ended September 30, 2007 and 2006, respectively. Revenues from the rental and sale of durable medical equipment include the rental and sale of items such as hospital beds, wheelchairs, walkers, patient aids and ancillary supplies. We derive a majority of our revenues from reimbursement by third party payors, including Medicare, Medicaid, the Department of Veterans Affairs and private insurers. Revenue derived from Medicare, Medicaid and other federally funded programs represented 65.4% and 67.5% of our patient revenue for the three months ended September 30, 2007 and 2006, respectively and 66.1% and 67.8% of our patient revenue for the nine months ended September 30, 2007 and 2006, respectively.

We are focused on specific initiatives to continue the growth in patient and product counts experienced during 2005 and 2006. These initiatives include expanded sales and operational training programs, as well as new sales commission and recognition programs. We believe these programs will better equip and motivate our sales force, and ultimately drive additional growth. In addition, we have reorganized our billing center employees into cross-functional teams, increased billing center staffing levels, and reduced our reliance on temporary labor in order to improve operating efficiencies. We also continue to actively monitor and manage our cash position and capital expenditures on a daily basis.

##### *Strategic Initiatives*

As a result of our highly leveraged position and the regulatory environment in which we operate, we continue to review various strategic transactions, such as an acquisition, sale, debt exchange or equity offering or a combination of any such transactions. We believe that a strategic transaction may be necessary to delever our balance sheet and strengthen our operating and financial conditions. Such a transaction could also strengthen our competitive position.

On March 30, 2007, we entered into a credit agreement (the "Credit Agreement") with the lenders that are parties thereto (the "Lenders"). Pursuant to the Credit Agreement, the Lenders have provided a payment-in-kind term loan facility in an aggregate principal amount of \$180.0 million (the "Senior Facility"). We used the proceeds of the Senior Facility to (i) repay all amounts due under our former credit agreement dated as of September 15, 2006 and terminated such agreement in connection therewith, (ii) pay associated transaction costs, and (iii) cash collateralize our existing letters of credit. We expect to use the balance of the loan for general working capital purposes. The Senior Facility is scheduled to mature on September 26, 2011 and the obligations thereunder are secured by substantially all of our assets and the assets of our subsidiaries. The interest rate under the Senior Facility is equal to the Base Rate plus 5% or the Eurodollar Rate plus 6% (11.4% as of September 30, 2007). The interest period, at our election, can be one, two, three or six months. Upon each renewable term we have the ability to change the interest period. As a payment-in-kind term loan facility, accrued interest is added to the principal amount on each interest payment date, provided that we may, at our election, pay any such accrued interest in cash on such date. We have not elected to pay any such accrued interest in cash during the nine months ended September 30, 2007. Accordingly, during the three and nine months ended September 30, 2007, \$5.2 million and \$7.0 million, respectively, in accrued interest has been added to the principal amount on the applicable interest payment dates (representing all accrued interest under the payment-in-kind term loan that became payable during such periods), increasing the principal amount outstanding to \$187.0 million as of September 30, 2007. As of September 30, 2007, we have \$3.6 million in accrued interest on the payment-in-kind term loan. We believe that the increased liquidity and less restrictive financial covenants provided under this Credit Agreement put us in a better position to pursue a strategic transaction.

### *Medicare Laws and Regulations*

Under existing Medicare laws and regulations, the sale and rental of our products generally are reimbursed by the Medicare program according to prescribed fee schedule amounts calculated using statutorily-prescribed formulas. The Balanced Budget Act of 1997 granted authority to the Secretary of the Department of Health and Human Services, or DHHS, to increase or reduce the fee schedule amounts for home medical equipment, including oxygen, by up to 15% each year under an inherent reasonableness procedure. The final rule implementing the inherent reasonableness authority establishes a process for adjusting payments for certain items and services covered by Medicare Part B when existing payment amounts are determined to be grossly excessive or deficient. Using its inherent reasonableness authority, the Centers for Medicare and Medicaid Services, or CMS, the agency within the DHHS responsible for administering the Medicare program, and its contractors may reduce reimbursement levels for certain items and services covered by Medicare Part B, including products and services we offer, which could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

In addition to its inherent reasonableness authority, CMS has the discretion to reduce the reimbursement for home medical equipment, or HME, and other non-HME services to an amount based on the payment amount for the least costly alternative treatment that meets the Medicare beneficiary's medical needs. Least costly alternative, or LCA, determinations may be applied to particular products and services by CMS and its contractors through the informal notice and comment process used in establishing local coverage policies for HME. This process need not be followed for LCA determinations made on individual claims. Using either its inherent reasonableness or LCA authority, CMS and its contractors may reduce reimbursement levels for certain items and services covered by Medicare Part B, including products and services we offer, which could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. Our business has been, and will continue to be, significantly impacted by changes mandated by Medicare legislation. The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, significantly changed the Medicare reimbursement methodology and conditions for coverage for a number of our products. These changes include a freeze in reimbursement rates for home medical equipment from 2004 to 2008, competitive bidding requirements, new clinical conditions for reimbursements, accreditation requirements and quality standards.

(1) Competitive Bidding for HME. On April 2, 2007, CMS released its final rule implementing a competitive bidding program for certain HME products under Medicare Part B. This nationwide competitive bidding program is designed to replace the existing fee schedule payment methodology. Under competitive bidding, suppliers compete for the right to provide items to beneficiaries in a defined region. CMS will select contract suppliers that agree to receive as payment the "single payment amount" calculated by the agency after bids are submitted. The deadline for submitting bids was September 25, 2007, and we submitted our bids on July 19, 2007 for the first round of competitive bidding for each of the respective metropolitan statistical areas, or MSAs, and product categories in which we intend to participate. CMS is scheduled to conclude bid evaluation and begin the contracting process in January 2008. CMS will announce winning suppliers for the first round in March 2008 and conduct intensive beneficiary and referral agent education from April 1, 2008 to July 1, 2008. The effective date for the first round of the program is now scheduled to begin on July 1, 2008. Selected suppliers must agree to offer each item in product categories selected under the program at the single payment amount.

The competitive bidding program is scheduled to begin in 2008 in ten high-population MSAs, expanding to 80 MSAs in 2009 and additional areas thereafter. In connection with the selection of MSAs, CMS designates by zip code specific areas in which competitive bidding will take place. These areas are referred to as competitive bidding areas or CBAs and may not be congruent with the boundaries of selected MSAs. Only a limited number of suppliers will be selected in any given CBA, resulting in restricted supplier choices for beneficiaries. MMA permits certain exemptions from competitive bidding, including exemptions for rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail-order for the particular item. A large number of our facilities are located in such areas. In its final rule, CMS indicates that it will determine whether to exempt from the competitive bidding program rural areas and areas with low population density within urban areas that are not competitive by examining low utilization (in terms of number of items or allowed charges for those items), low Medicare fee-for-service population, and/or a low number of suppliers. The impact of such an exemption on our business remains uncertain.

In a press release issued on the same date as the final rule, CMS announced the first ten MSAs for 2007 and the product categories selected for the first round of bidding. The MSAs include Charlotte-Gastonia-Concord, North Carolina-South Carolina; Cincinnati-Middletown, Ohio-Kentucky-Indiana; Cleveland-Elyria-Mentor, Ohio; Dallas-Fort Worth-Arlington, Texas; Kansas City, Missouri-Kansas; Miami-Fort Lauderdale-Miami Beach, Florida; Orlando, Florida; Pittsburgh, Pennsylvania; Riverside-San Bernardino-Ontario, California; and San Juan-Caguas-Guaynabo, Puerto Rico. We currently operate in nine of these ten MSAs. Suppliers do not need to be physically located in the CBA to submit a bid. The following product categories (all of which we offer for rent or sale), among others, will be subject to competitive bidding in 2007: oxygen supplies and equipment; continuous positive airway pressure, or CPAP, devices, respiratory assist devices or RADs, and related supplies and accessories; standard power wheelchairs, scooters, and related accessories; hospital beds and related accessories; and walkers and related accessories. Each product category subject to competitive bidding is comprised of individual Healthcare Common Procedure Coding System, or HCPCS codes. To bid on a product, a supplier (or a network of small suppliers) must submit bids on the full spectrum of HCPCS codes contained in that product's category. In addition, commonly-owned suppliers may submit only one bid. Once bids are submitted, CMS determines the composite bid for each product category and arranges them from highest to lowest to select a "pivotal bid" at the point where the expected combined capacity of the bidders is sufficient to meet expected beneficiary demand for items in a category. CMS will award at least five contracts in each CBA, however, if there are less than five suppliers bidding then at least two contract suppliers must be selected for each CBA.

In its final rule, CMS also adopted its proposal to grandfather rental agreements between beneficiaries and non-contract suppliers that pre-date the competitive bidding program in a CBA. A supplier that furnishes certain equipment on a rental basis to a beneficiary prior to the implementation of competitive bidding in a CBA can choose to continue furnishing the item as a grandfathered supplier, without participating in the competitive bidding process. Payment for grandfathered items furnished during the initial phase of the competitive bidding program implemented in a specific CBA will be as follows: capped rental items will be paid the applicable fee schedule amount paid in areas not subject to competitive bidding; and oxygen and oxygen equipment will be paid the single payment amount, which is the payment rate under the competitive bidding program for the CBA. During future rounds of competitive bidding, all grandfathered items will receive the single payment amount.

Under its final rule, if the grandfathering option is not exercised, CMS will require contract suppliers to assume existing rental agreements from non-contract suppliers. Contract suppliers furnishing oxygen equipment will be guaranteed a minimum of ten months of rental payments. For instance, a contractor who assumes a rental agreement for oxygen in month 11 will receive the single payment rate for the remaining 25 months of rental and title transfers to the beneficiary after month 36 (see Deficit Reduction Act discussion herein). A contractor who assumes a rental agreement in month 30, however, nonetheless will receive ten months of rental payments even though this results in more than a total of 36 months of payment before title transfers. Suppliers who assume agreements for capped rental items will receive at least 13 months of rental payments, or the full rental period, regardless of when the rental agreement is assumed. In addition, CMS had proposed to require contract suppliers to repair or replace patient-owned items subject to competitive bidding, but in response to concerns that contract suppliers should not have to offer repairs for equipment never stocked, CMS will pay for the maintenance and servicing, including replacement parts, of competitively bid items that are performed by any supplier, not just contract suppliers. As to replacements, however, CMS will require that beneficiaries obtain replacements for entire items from contract suppliers.

Until such time that the bids are awarded and the associated fee schedules and participating providers are announced, we will not be able to determine the impact of the final rule, nor can we predict the effect the process will have on our ability to continue to provide products to Medicare beneficiaries.

(2) Certain Clinical Conditions, Accreditation Requirements and Quality Standards. The MMA requires that new clinical conditions of coverage for HME products and quality standards for HME suppliers be established and implemented. Some clinical conditions have been implemented, such as the requirement for a face-to-face visit by treating physicians for beneficiaries seeking power mobility devices. On August 14, 2006, CMS published its quality

standards for HME suppliers. As an entity that bills Medicare and receives payment from the program, we are subject to these standards. We have revised our policies and procedures to ensure compliance in all material respects with the quality standards. These standards, which became effective upon publication, will be applied by independent accreditation organizations. The final standards include business-related standards, such as financial and human resources management requirements, which would be applicable to all HME suppliers, and product-specific quality standards, which focus on product specialization and service standards. The product-specific standards address several of our products, including oxygen and oxygen equipment, CPAP and power and manual wheelchairs and other mobility equipment. The final rule on competitive bidding requires that all suppliers meet these new quality standards and also meet additional financial standards. As part of the supplier bidding process, suppliers must submit documentation that includes schedules from tax returns, a copy of SEC Form 10-K filings for the previous three years (for public companies), certain specific financial statements that include cash flow statements and a copy of current credit reports. At this time, however, we cannot predict the full impact that the clinical conditions, final quality standards or financial standards will have on our business or the effect such conditions and standards will have on our ability to continue to provide products to Medicare beneficiaries.

On July 31, 2006, CMS released a final rule, which implements criteria for accrediting organizations to be selected by CMS to apply the final quality standards. In addition, on November 22, 2006, CMS announced that the Joint Commission on Accreditation of Healthcare Organizations, or the Joint Commission, has been selected to be one of the recognized accrediting organizations. Currently, all of our operating centers are accredited by the Joint Commission. Suppliers must become accredited by October 31, 2007 to be selected as a contract supplier. CMS has also indicated informally that selected accreditation organizations, such as the Joint Commission, have authority to determine whether suppliers that are already accredited can be “grandfathered” or must undergo additional accreditation measures. However, the final accreditation rule does not provide us with sufficient information to predict the full impact of the final accreditation criteria on our business. The full impact of the accreditation requirements is uncertain at this time.

(3) Reduction in Payments for HME and Inhalation Drugs. The MMA changes also include a reduction in reimbursement rates for oxygen equipment and certain other items of home medical equipment (including wheelchairs, nebulizers, hospital beds and air mattresses) as of January 1, 2005, based on the percentage difference between the amount of payment otherwise determined for 2002 and the 2002 median reimbursement amount under the Federal Employee Health Benefits Program, or FEHBP, as determined by the Office of the Inspector General of the DHHS, or OIG. The FEHBP adjusted payments are to remain “frozen” through 2008 unless the particular item becomes subject to competitive bidding.

On March 30, 2005, CMS released the Medicare fee schedule amounts for oxygen equipment that reflected the FEHBP reductions. Reductions in payment rates for 2005 established by CMS for the non-oxygen HME items subject to the FEHBP provisions ranged between 4% and 16%. The non-oxygen HME items subject to the Medicare price cuts accounted for approximately 4.1% of our recorded revenues for the year ended December 31, 2006. Furthermore, the reductions in the Medicare fee schedules for home oxygen equipment together with the additional reimbursement reductions mandated by the MMA in 2005 for other home medical equipment (excluding inhalation drugs) resulted in an aggregate reduction in our recorded revenues in the amount of approximately \$17.9 million and \$17.7 million for the years ended December 31, 2006 and 2005, respectively. Any additional reductions in Medicare reimbursement rates for home oxygen equipment could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. Subsequent changes to the fee schedule amounts for oxygen equipment, which became effective beginning 2007, are discussed below.

MMA also revised the payment methodology for certain drugs, including inhalation drugs dispensed through nebulizers. For the nine months ended September 30, 2007, Medicare-reimbursed inhalation drug therapies provided by us accounted for approximately 19.3% of our recorded revenues after allowing for the reduction in revenues related to the decreased reimbursement rate for compounded budesonide, which is further described below.

In addition to MMA changes in payment methodology, given the overall reduction in payment for inhalation drugs dispensed through nebulizers, CMS established a dispensing fee for inhalation drugs shipped to a beneficiary. The 2005 dispensing fee was \$57 for a 30-day period or \$80 for a 90-day period. Effective January 1, 2006, the dispensing fee for inhalation drugs furnished to beneficiaries remained at \$57 for the first 30-day period in which a Medicare beneficiary uses inhalation drugs and was reduced to \$33 for each subsequent 30-day period. The dispensing fee for a 90-day supply of inhalation drugs was likewise reduced to \$66. These reductions in the 2006 Medicare dispensing fees reduced our net revenue by approximately \$9.8 million for the year ended December 31, 2006. Although the dispensing fee for 2007 remains unchanged from the 2006 rate, future dispensing fee reductions or eliminations, if they occur, could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

Effective January 1, 2006, CMS established a new billing code and payment methodology for compounded budesonide, which includes compounded budesonide formulations that we provided to Medicare beneficiaries based on a physician's prescription. Medicare reimbursement rates for compounded budesonide, beginning January 1, 2006, are based on pharmacy invoices submitted for individual claims. This payment amount reflects a reimbursement rate based on the acquisition of raw materials and is far below the prior years' payment amounts. For the year ended December 31, 2006, the new reimbursement rates for compounded budesonide resulted in a reduction in our recorded revenues of approximately \$30.4 million.

Effective January 1, 2007, CMS established new billing codes and payment methodologies for other compounded inhalation drugs, including albuterol and ipratropium. The revised codes distinguish compounded from non-compounded drugs, and Medicare payments for compounded formulations are to be based on invoices for the compounded materials. In March 2007, as discussed further below, final Medicare coverage policies were issued, announcing discontinuation of coverage for compounded inhalation drugs, effective for claims with dates of service on or after July 1, 2007. Our compounding activities with respect to other inhalation drugs were not material and as of April 1, 2007, we have discontinued all compounding operations. As such, we do not expect that this discontinuation of coverage will have a material adverse effect on our revenues, profit margins, profitability, operating cash flows or results of operations.

Effective July 1, 2007, CMS also revised its billing codes for non-compounded albuterol and levalbuterol. Under CMS's revised policy, the existing HCPCS codes for these products are no longer permitted to be used for Medicare claims. Instead, two new HCPCS codes were established; new code Q4093 is to be used for claims for the concentrated formulation of both albuterol and levalbuterol, and new code Q4094 is to be used for claims for the single dose form of both albuterol and levalbuterol. CMS has set payment levels for the new HCPCS codes based on the weighted average of the average sales prices, or ASPs, for each product assigned to the respective codes. The 2007 payment rates for concentrated albuterol and concentrated levalbuterol are as follows:

Medicare payment rates effective:	Concentrated Albuterol (1mg)	Concentrated Levalbuterol (.5mg)	Single Dose Albuterol	Single Dose Levalbuterol
1/1/2007 – 3/31/2007	\$ 0.071	\$ 0.989	\$ 0.163	\$ 3.478
4/1/2007 – 6/30/2007	\$ 0.071	\$ 0.922	\$ 0.203	\$ 3.838
7/1/2007 – 9/30/2007	\$ 0.127	\$ 0.127	\$ 1.313	\$ 1.313
10/1/2007 – 12/31/2007	\$ 0.131	\$ 0.131	\$ 1.048	\$ 1.048

To date, the reductions in payment rates for single dose levalbuterol have been offset by reductions in cost of sales for single dose levalbuterol and by increased payment rates for single dose albuterol. However, we expect that future decreases for single dose albuterol and levalbuterol claims could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. At this time, the full effect of the coding and payment revisions on our revenues, profit margins, profitability, operating cash flows and results of operations remains uncertain.

In addition to the abovementioned changes for inhalation drugs, in March 2006, Medicare contractors issued a draft local coverage determination, or LCD, for nebulizers and inhalation drugs dispensed through nebulizers that are covered by Medicare Part B, which proposes to change significantly the payment rates and coverage criteria for several inhalation drugs that we dispense to beneficiaries, in part using the LCA mechanism discussed above. Specifically, the draft LCD proposed to reduce the payment amount for two FDA-approved drugs. The formulation of levalbuterol (commercially available under the name "Xopenex<sup>®</sup>") would be reduced to the maximum allowable payment for generic albuterol, and the payment amount for the commercially available combination of albuterol and ipratropium (commercially available under the name "DuoNeb<sup>®</sup>") to the maximum allowable payment for separate unit dose vials of albuterol and ipratropium. In March 2007, the final LCD was issued, removing coverage for compounded nebulizer formulations. The LCD did not change existing coverage for Xopenex<sup>®</sup> or DuoNeb<sup>®</sup>. Instead, the Medicare contractors deferred rendering a final decision on these two drugs until CMS completed its pending national coverage analysis. CMS initiated the national coverage analysis in December 2006 to evaluate Medicare coverage at the national level for beta adrenergic agonist therapy drugs used for lung diseases. As part of the national coverage analysis process, on June 20, 2007, CMS released a proposed decision memorandum which concluded that CMS has insufficient information based on published medical evidence to define specific patient populations who would benefit from a particular treatment with particular medications. As a result, CMS announced in its proposed decision memorandum that it would not issue a national coverage decision and instead would leave to CMS contractors to render local decisions regarding coverage for nebulized beta adrenergic agonist therapy for lung diseases either through an LCD or through claim reviews on a case-by-case basis. This means, for example, if CMS does not otherwise issue a national coverage decision, its Medicare contractors could require the pricing of DuoNeb<sup>®</sup> to be set based on an LCA analysis at the maximum allowable payments for separate unit dose vials of its component drugs, albuterol and ipratropium, which could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. In addition, the introduction into the marketplace of generic alternatives for DuoNeb<sup>®</sup> could result in a decreased ASP and a corresponding decreased Medicare payment rate for the commercially-available combination product. However, at this time, we cannot predict the full impact of such a decrease in ASP or the full impact of an LCA analysis or CMS's proposed decision memorandum on our revenues, profit margins, profitability, operating cash flows and results of operations.

## *Deficit Reduction Act*

The Deficit Reduction Act of 2005, or DRA, which was signed into law on February 8, 2006, also has made certain changes to the way Medicare Part B pays for our HME products, including capped rental items and oxygen equipment. For capped rental items, including hospital beds, nebulizers and power wheelchairs, Medicare has in the past paid a monthly rental fee for a period not to exceed 15 months of continuous use. Under the DRA, the maximum number of months for which Medicare is to make payment for such equipment decreased from 15 months to 13 months of continuous use, after which time ownership is automatically transferred to the beneficiary. This provision is effective for items furnished for which the first rental month is during or after January 2006. As to power wheelchairs, the DRA preserves an existing provision requiring that beneficiaries be given the option to purchase the power wheelchair at the time it is furnished. For oxygen equipment, prior to the DRA, Medicare made monthly rental payments indefinitely, provided medical need continued. The DRA capped the Medicare rental period for oxygen equipment at 36 months of continuous use, after which time ownership of the equipment transfers to the beneficiary. For purposes of this cap, the DRA provides for a new 36-month rental period that began January 1, 2006 for all oxygen equipment. This new 36 month rental period applies for beneficiaries starting to use the equipment as well as for those who have been using it prior to 2006. In addition to the changes in the duration of the rental period for capped rental items and oxygen equipment, the DRA authorizes payments for servicing and maintenance of the products after ownership transfers to the beneficiary if the Secretary of the Department of Health and Human Services determines the servicing and maintenance is reasonable and necessary. Prior to the changes by the DRA to the duration of the capped rental period and the new transfer of ownership requirement, Medicare payment for the capped rental items was made automatically every six months for servicing and maintenance for those products for which a Medicare supplier retained ownership after the capped rental period ended.

On November 1, 2006, CMS released a final rule to implement the DRA changes, which went into effect January 1, 2007. Under the rule, CMS explains the DRA's 36-month rental cap on oxygen equipment that began on January 1, 2006. CMS also revised categories and payment amounts for the oxygen equipment and contents during the rental period and for oxygen contents after equipment ownership by the beneficiary as follows:

- *Payment for Rental Period.* For stationary oxygen equipment, the 2007 payment amount is \$198.40, a decrease of \$1.44 from the 2006 amount. The portable oxygen add-on amount remains unchanged from 2006, at \$31.79. CMS also created a new class for oxygen-generating portable oxygen equipment and a new monthly rental payment amount of \$51.63 for this equipment.
- *Payment for Contents After Beneficiary Ownership.* Payment is based on the type of equipment owned and whether it is oxygen-generating. Previously, CMS paid a combined average monthly payment amount of \$154.90 for furnishing oxygen contents for beneficiary-owned stationary and portable systems. This amount included payment for both stationary contents and portable contents. CMS will split this payment into a separate monthly payment amount for stationary oxygen content of \$77.45 and a separate monthly payment amount for portable oxygen content of \$77.45. This payment amount is for oxygen contents for equipment that is not oxygen-generating. If the beneficiary owns both stationary and portable equipment that is not oxygen-generating, the monthly payment amount for oxygen contents is \$154.90. For stationary or portable oxygen equipment that is oxygen-generating, there will be no monthly payment for contents.

In its November 1, 2006 final rule, CMS also acknowledges certain other payments after ownership transfers, including payment for supplies such as tubing and masks. In addition, CMS details several requirements regarding a supplier's responsibility to maintain and service capped rental items and provides for a general maintenance and servicing payment for certain oxygen-generating equipment beginning six months after title has transferred to the beneficiary. While we do not expect the changes in rental periods and payment amounts for capped rental items and oxygen equipment to have a material impact on our business in 2007, at this time, we anticipate that the changes in rental period for capped rental items and oxygen equipment will have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations beginning in 2009. We cannot predict the impact that any future rulemaking by CMS will have on our business. If payment amounts for oxygen equipment and contents are further reduced in the future, this could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

President George W. Bush's proposed 2008 budget includes a further reduction in the maximum rental period for home oxygen equipment from 36 months to 13 months. Additionally, on August 1, 2007, the U.S. House of Representatives passed H.R. 3162, "The Children's Health and Medicare Protection Act." This legislation would reduce payments to Medicare Advantage plans and increase the federal cigarette tax by 45 cents per pack to increase funding for the State Children's Health Insurance Program (SCHIP) by \$50 billion over five years. This legislation also would reduce the oxygen equipment rental cap from 36 months to 18 months. On August 2, 2007, the U.S. Senate passed S 1893. This legislation would reauthorize SCHIP and increase the cigarette tax by 61 cents per pack to fund a SCHIP expansion of \$35 billion over 5 years. As passed by both the House and Senate, the SCHIP legislation did not contain the proposed provisions affecting oxygen equipment providers. In addition, the President vetoed the SCHIP legislation on October 3, 2007 and the U.S. House of Representatives failed to override the President's veto.

Provisions impacting oxygen reimbursement may be reintroduced in future legislation. However, we cannot predict what changes would be made to existing or proposed legislation and are therefore unable to estimate at this time the impact future legislation would have on our business.

#### *Surety Bond Proposal*

On August 1, 2007, CMS published a proposed rule that would require all HME suppliers, except those that are government-operated, to obtain and furnish a surety bond to the National Supplier Clearinghouse, or NSC, the Medicare contractor responsible for enrollment, for each Medicare supplier number held. CMS previously issued a proposed surety bond requirement in 1998 to implement BBA 97. At that time, the proposed surety bond amount was \$50,000; CMS has adjusted the proposed surety bond amount to \$65,000 to reflect inflation. CMS seeks public comments on, among other things, whether the surety bond amount should be increased for so-called “higher-risk” suppliers and whether to establish an exception to the requirement for publicly traded chain suppliers. It is unclear whether the proposal would exempt publicly traded chain suppliers of HME, or whether we would be made subject to such an exemption. If this proposal were enacted and if no such exemption is included, or if we were otherwise not subject to such an exemption, we would be required to obtain surety bonds for each of our approximately 500 locations, resulting in significant additional cost in operating our business.

#### *Medicare Demonstration Project*

On June 28, 2007, CMS announced plans to implement a two-year demonstration project involving the Medicare enrollment of suppliers of durable medical equipment, prosthetics, orthotics and supplies. The stated goal of the project is to strengthen CMS’s ability to detect and prevent fraudulent activity, focusing specifically on suppliers physically located in Miami-Dade, Broward and Palm Beach Counties, Florida and in Los Angeles, Orange, Riverside and San Bernardino Counties, California. HME suppliers in these locales will be required to submit a reenrollment application for participation in Medicare upon request from the NSC. Under the project, CMS intends to revoke a supplier’s Medicare billing privileges if the supplier (1) fails to submit a reenrollment application within a 30-day timeframe of receiving a request from the NSC, (2) fails to report any change in ownership or address at least 30 days prior to the effective date of the change, (3) fails to obtain accreditation from a CMS-approved accrediting organization within 90 days of notification from the NSC, (4) has an owner or managing employee that has had a felony conviction within the last 10 years, or (5) no longer meets each requirement necessary for enrollment as a Medicare supplier. If the supplier’s billing privileges are revoked, CMS will implement appropriate recoupment measures. In addition, suppliers that do not have their Medicare billing privileges revoked based on the information contained in the reenrollment application they submitted will be subject to an enhanced review. We believe that we will be made subject to this demonstration project as we are enrolled in several of the locales subject to the project. We cannot, however, predict whether any adverse action will be taken against us pursuant to the demonstration project, nor can we predict the effect that any such adverse action would have on our revenues, profit margins, profitability, operating cash flows and results of operations.

#### *Federal and State Regulatory Requirements*

Under the Federal Food Drug and Cosmetic Act (FFDCA), the FDA imposes stringent regulations on the distribution, labeling, and other aspects of our medical gas and pharmacy operations. In particular, our medical gas facilities and operations are subject to the FDA’s current Good Manufacturing Practice (cGMP) regulations, and similar state regulations, which impose certain quality control, documentation, labeling and recordkeeping requirements on the receipt, processing and distribution of medical gas. We are required to register our medical gas facilities with the FDA, and are subject to periodic, unannounced inspections by the FDA and state authorities for compliance with the cGMP and other regulatory requirements. Our sites have historically been subject to regular inspections by regulatory authorities. We have received notices of inspectional observations at the conclusion of many of these inspections. Where required, we have taken corrective actions to address the inspectional observations identified during these inspections.

We continue to expend significant time, money and other resources in our effort to achieve substantial compliance with the FDA’s cGMP regulations and the state laws applicable to our medical gas operations in the jurisdictions in which we do business. Failure to comply with the FDA and other federal and state regulatory requirements could subject us to possible legal or regulatory action, such as warning letters, product seizure or recalls, suspension of operations at a single facility or several facilities, temporary or permanent injunctions, or possible civil or criminal penalties.

### *Pharmacy Licensing, Registration and Regulatory Requirements*

Under state law, our pharmacy locations must be licensed as in-state pharmacies to dispense pharmaceuticals in the relevant state of location. We deliver pharmaceuticals from our pharmacy location in Kentucky to customers in 47 states, and, where required by state pharmacy law, we must obtain and maintain licenses from each state to which we deliver pharmaceuticals. Most states, and the FDA, adopt and enforce the official standards of the US Pharmacopeia (USP) as the official compendia of drug standards. We are subject to state boards of pharmacy laws and regulations in nearly all jurisdictions where we do business. These laws vary from state to state and state lawmakers regularly propose and, at times, enact new legislation establishing changes in state pharmacy laws and regulations. We continuously monitor state activities and the USP and we have policies in place that we believe substantially comply with all state licensing and pharmacy laws currently applicable to our business, although there can be no assurance that we always operate in full compliance with our policies. Further, there can be no assurance that we are fully and immediately in compliance with all laws, regulations or standards at all times, as licenses may lapse and laws may change or be misinterpreted or overlooked. Failure to comply with applicable regulatory requirements can result in enforcement action, including fines, revocation, suspension of or refusal to renew licensure, injunctions, seizures, and civil or criminal penalties. Further, we are required to maintain state licenses and permits in those states in which we are doing business to meet Medicare and Medicaid requirements. A finding that the state requirements have not been met can result in the recoupment of reimbursement or revocation of our supplier numbers. If we are unable to obtain and maintain our licenses in one or more states, or if such states place burdensome restrictions or limitations on pharmacies, our ability to operate in such states, including doing Medicare and Medicaid business in such state or states, would be limited, which could adversely impact our revenues, profit margins, profitability, operating cash flows and results of operations.

In August 2005, the FDA inspected the compounding activities at our Pulmo-Dose pharmacy and presented us with an FDA Form 483 noting three inspectional observations. We submitted a response to the FDA Form 483 and engaged in subsequent communications with the FDA regarding the inspection and the FDA's review of Pulmo-Dose's activities. On August 10, 2006, we received a warning letter from the FDA stating that Pulmo-Dose's compounding of formulations of budesonide, albuterol/ipratropium, and formoterol/budesonide exceeded the scope of the practice of pharmacy and that Pulmo-Dose was operating as a pharmaceutical manufacturer. We submitted a formal response to the warning letter on August 30, 2006 and continued to engage in written and oral communications with the FDA regarding their assertions.

In light of the FDA's warning letter and subsequent communications, we have discontinued all of our pharmacy compounding operations as of April 2007. We are not accepting any new prescriptions for compounded product, and we have in collaboration with our patients' physicians, switched patients from their prescribed compounded products to drug products that are commercially available, where clinically appropriate. The transition of these patients to commercially available alternative products has positively impacted our revenues during 2007 when compared to 2006. These commercially available alternative products have lower margins, resulting in a material adverse effect on our profit margins, profitability, operating cash flows and results of operations in 2007 when compared to the reimbursements for the compounded products under the prior billing code and payment methodology in effect prior to 2006. The FDA conducted a follow-up inspection of Pulmo-Dose to evaluate our compliance with our phase-out plan and the FFDCA in May 2007. At the conclusion of this inspection, the FDA inspector stated that because Pulmo-Dose had ceased its compounding operations, the FDA considered the matter closed. However, to date, we have not received written confirmation of the FDA's decision.

### *General*

As a health care supplier, we are subject to extensive government regulation, including numerous laws directed at preventing fraud and abuse and laws regulating reimbursement under various government programs. The marketing, billing, documenting and other practices of health care companies are all subject to government scrutiny. Numerous federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), govern the collection, dissemination, use and confidentiality of patient-identifiable health information. As part of our provision of, and billing for, health care equipment and services, we are required to collect and maintain patient-identifiable health information. Violations of federal and state regulations can result in severe criminal, civil and administrative penalties and sanctions, including disqualification from Medicare and other reimbursement programs. Health care is an area of rapid regulatory change. Changes in the laws and regulations and new interpretations of existing laws and regulations may affect permissible activities, the relative costs associated with doing business, and reimbursement amounts paid by federal, state and other third-party payors. We cannot predict the future of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations. Future legislative and regulatory changes could have a material adverse impact effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

### *Health Insurance Portability and Accountability Act of 1996*

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, mandates, among other things, the establishment of regulatory standards addressing the electronic exchange of health information, standards for the privacy and security of health information and standards for assigning unique health identifiers to health care providers. Sanctions for failure to comply with HIPAA standards include civil and criminal penalties.

Three standards have been promulgated under HIPAA with which we currently are required to comply. The Standards for Electronic Transactions require the use of standardized transactions and code sets for common health care transactions involving the exchange of certain types of information, including health care claims or equivalent encounter information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, health plan premium payments, and coordination of benefits. The Standards for Privacy of Individually Identifiable Information restricts use and disclosure of certain individually identifiable health information, called protected health information, or "PHI". These Privacy Standards not only require our compliance with standards restricting the use and disclosure of PHI, but also require us to obtain satisfactory assurances that any business associate of ours who has access to our PHI similarly will safeguard such PHI. The Security Standards require us to implement certain security measures to protect electronic PHI. We believe that we are in compliance in all material respects with each of these HIPAA standards.

One other standard has been promulgated under HIPAA, although compliance with this standard is not yet required. CMS published a final rule covering the assignment of Unique Health Identifiers for Health Care Providers. The rule calls for the adoption of the National Provider Identifier as the standard unique health identifier for health care providers to use in filing and processing health care claims and other transactions. We are required to comply with this standard by May 23, 2007. On April 2, 2007, CMS announced that covered entities who do not expect to be in compliance with this standard by May 23, 2007 may implement contingency plans for an additional twelve month period through May 23, 2008. During this period, CMS will not impose penalties on covered entities who implement contingency plans if they have made reasonable and diligent efforts to become compliant with the rule. We have evaluated this rule to determine the effects of the rule on our business. We believe that we have taken the appropriate steps to ensure that we are in compliance with this standard in all material respects.

HIPAA also has created health care related crimes, and granted authority to the Secretary of the DHHS to impose certain civil penalties. Particularly, the Secretary may exclude from Medicare any individual with a direct or indirect ownership interest in an entity convicted of health care fraud or excluded from the program. HIPAA encourages the reporting of health care fraud by allowing reporting individuals to share in any recovery made by the government. HIPAA also requires new programs to control fraud and abuse, and new investigations, audits and inspections.

Under HIPAA it is a crime to:

- knowingly and willfully commit a federal health care offense relating to a health care benefit program; and
- knowingly and willfully falsify, conceal or cover up a material fact or make any materially false or fraudulent statements in connection with claims and payment for health care services by a health care benefit plan.

These provisions of HIPAA create criminal sanctions for situations that were previously handled exclusively through civil repayments of overpayments, off-sets and fines. While we believe we comply in all material respects with these HIPAA requirements, we cannot provide any assurance that governmental authorities will find that our business practices comply with current or future administrative or judicial interpretations of HIPAA and its implementing regulations. A violation could subject us to penalties, fines or possible exclusion from Medicare or Medicaid. Such sanctions could reduce our revenue or profits.

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.

## Results of Operations

The following table shows our results of operations for the three and nine months ended September 30, 2007 and 2006 (in thousands).

	Three months ended September 30,		Nine months ended September 30,	
	2007	2006	2007	2006
Net revenues	\$140,933	\$127,218	\$420,624	\$ 371,537
Cost of net revenues:				
Product and supply costs	33,605	24,525	107,903	73,530
Patient service equipment depreciation	12,283	11,202	35,921	33,532
Operating costs	6,252	5,757	18,113	18,332
Total cost of net revenues	52,140	41,484	161,937	125,394
Provision for doubtful accounts	5,163	3,464	13,748	10,900
Selling, general and administrative	73,050	71,664	224,021	225,273
Depreciation and amortization	3,511	3,948	10,898	13,039
Goodwill impairment	—	80,000	—	529,000
Total costs and expenses	133,864	200,560	410,604	903,606
Operating income (loss)	7,069	(73,342)	10,020	(532,069)
Interest expense, net	12,099	9,544	34,194	26,687
Other income, net	(385)	(203)	(337)	(127)
Loss on extinguishment of debt	—	1,212	12,171	1,212
Loss before income taxes	(4,645)	(83,895)	(36,008)	(559,841)
Federal and state income tax benefit	(1,583)	—	(4,611)	(42,290)
Net loss	(3,062)	(83,895)	(31,397)	(517,551)
Accrued dividends on redeemable preferred stock	113	113	338	338
Net loss attributable to common stockholders	<u>\$ (3,175)</u>	<u>\$ (84,008)</u>	<u>\$ (31,735)</u>	<u>\$ (517,889)</u>

The following table shows our results of operations as a percentage of our net revenues for the three months and nine months ended September 30, 2007 and 2006.

	Three months ended September 30,		Nine months ended September 30,	
	2007	2006	2007	2006
Net revenues	100.0%	100.0%	100.0%	100.0%
Cost of net revenues:				
Product and supply costs	23.8%	19.3%	25.7%	19.8%
Patient service equipment depreciation	8.7%	8.8%	8.5%	9.0%
Operating costs	4.4%	4.5%	4.3%	4.9%
Total cost of net revenues	36.9%	32.6%	38.5%	33.7%
Provision for doubtful accounts	3.7%	2.7%	3.3%	2.9%
Selling, general and administrative	51.8%	56.3%	53.3%	60.6%
Depreciation and amortization	2.5%	3.1%	2.6%	3.5%
Goodwill impairment	— %	62.9%	— %	142.4%
Total costs and expenses	94.9%	157.6%	97.7%	243.1%
Operating income (loss)	5.1%	(57.6)%	2.3%	(143.1)%
Interest expense, net	8.6%	7.5%	8.1%	7.2%
Other income, net	(0.3)%	(0.2)%	(0.1)%	— %
Loss on extinguishment of debt	— %	1.0%	2.9%	0.3%
Loss before income taxes	(3.2)%	(65.9)%	(8.6)%	(150.6)%
Federal and state income tax benefit	(1.1)%	— %	(1.1)%	(11.4)%
Net loss	(2.1)%	(65.9)%	(7.5)%	(139.2)%
Accrued dividends on redeemable preferred stock	0.1%	0.1%	0.1%	0.1%
Net loss attributable to common stockholders	(2.2)%	(66.0)%	(7.6)%	(139.3)%

### Three months ended September 30, 2007 as compared to the three months ended September 30, 2006

Total net revenues for the three months ended September 30, 2007 were \$140.9 million as compared to \$127.2 million for the comparable period in 2006. The net increase of \$13.7 million was primarily attributable to net revenue increases for the three months ended September 30, 2007 of:

- \$10.1 million from the transition of patients formerly receiving compounded budesonide to commercially available alternative products; and
- \$6.9 million from organic patient growth, net of changes in contractual adjustments, representing a 1.5% increase in oxygen patient counts and a 5.8% increase in CPAP product counts.

These increases in net revenue were offset by a decrease of \$3.3 million in net revenues for the three months ended September 30, 2007 as a result of the DRA reductions in oxygen reimbursement rates and changes in albuterol and levalbuterol reimbursement rates discussed above.

Cost of net revenues totaled \$52.1 million for the three months ended September 30, 2007, an increase of \$10.7 million or 25.7% from the comparable period in 2006. The net increase was primarily attributable to increased product and supply costs from the transition of patients formerly receiving compounded budesonide to commercially available alternative products less reductions in cost of sales on levalbuterol (Xopenex®). Cost of net revenues as a percentage of net revenue was 36.9% for the three months ended September 30, 2007 as compared to 32.6% for the comparable period in 2006.

The provision for doubtful accounts for the three months ended September 30, 2007 totaled \$5.2 million, a \$1.7 million increase from the comparable period in 2006. This increase was mainly attributable to uncollectible deductible amounts from patients, as well as increased revenues. The provision for doubtful accounts as a percentage of net revenues was 3.7% for the three months ended September 30, 2007 as compared to 2.7% for the three months ended September 30, 2006.

Selling, general and administrative expenses for the three months ended September 30, 2007 totaled \$73.1 million, an increase of \$1.4 million or 1.9% from the comparable period in 2006. Selling, general and administrative expenses as a percentage of net revenues decreased to 51.8% for the three months ended September 30, 2007 from 56.3% for the three months ended September 30, 2006, primarily as a result of the increase in net revenues during the three months ended September 30, 2007 as compared to the comparable period in 2006.

Depreciation and amortization for the three months ended September 30, 2007 totaled \$3.5 million, a decrease of \$0.4 million or 11.1% from the comparable period in 2006. This decrease is mainly the result of decreased capital expenditures on computer and other equipment, as well as certain computer and other equipment becoming fully depreciated during the last twelve months. Depreciation and amortization as a percentage of net revenue decreased to 2.5% as compared to 3.1% for the comparable period in 2006.

We recorded an estimated non-cash goodwill impairment charge of \$80.0 million for the three months ended September 30, 2006 as the result of an overall decline in our profitability which resulted primarily from decreases in Medicare reimbursement rates, including the reductions for compounded budesonide and the resulting decline in our market capitalization. We did not have any similar impairment charges during the three months ended September 30, 2007.

Net interest expense for the three months ended September 30, 2007 totaled \$12.1 million, an increase of \$2.6 million or 26.8% from the comparable period in 2006. The increase is primarily attributable to an increase of approximately \$93.6 million in the average debt outstanding during the three months ended September 30, 2007 as compared to the comparable period in 2006, as well as an increase of approximately 214 basis points in the average applicable variable interest rates.

Federal and state income net benefit for the three months ended September 30, 2007 was \$1.6 million. We did not record any expense or benefit for federal and state income taxes for the three months ended September 30, 2006. The current period tax benefit is primarily the result of the expiration of various statutes of limitations and a favorable settlement of an appeal of state income taxes related to 2002. We recorded \$0.5 million of professional fees, included in selling, general and administrative expenses for the three months ended September 30, 2007, associated with the handling of this appeal. The net settlement of \$1.1 million is included in income taxes receivable in the accompanying unaudited condensed consolidated balance sheet as of September 30, 2007.

Net loss for the three months ended September 30, 2007 was \$3.1 million compared to a net loss of \$83.9 million for the comparable period in 2006. As outlined above, we recorded an \$80.0 million non-cash goodwill impairment charge in 2006 that did not recur in 2007.

#### **Nine months ended September 30, 2007 as compared to the nine months ended September 30, 2006**

Total net revenues for the nine months ended September 30, 2007 were \$420.6 million as compared to \$371.5 million for the comparable period in 2006. The net increase of \$49.1 million was primarily attributable to net revenue increases for the nine months ended September 30, 2007 of:

- \$33.8 million from the transition of patients formerly receiving compounded budesonide to commercially available alternative products; and
- \$24.5 million from organic patient growth representing a 3.5% increase in oxygen patient counts and a 10.3% increase in CPAP product counts.

These increases in net revenues were offset by decreases in net revenues for the nine months ended September 30, 2007 of:

- \$5.1 million as a result of volume reductions under two of our contracts with Gentiva Health Services (“Gentiva”) as a result of an amendment to Gentiva’s contract with CIGNA Healthcare (“CIGNA”), whereby Gentiva would no longer coordinate specific respiratory therapy and DME services on behalf of CIGNA effective January 31, 2006; and
- \$4.1 million as a result of the DRA reductions in oxygen reimbursement rates and changes in albuterol and levalbuterol reimbursement rates discussed above.

Cost of net revenues totaled \$161.9 million for the nine months ended September 30, 2007, an increase of \$36.5 million or 29.1% from the comparable period in 2006. The net increase was primarily attributable to a increased product and supply costs from the transition of patients formerly receiving compounded budesonide to commercially available alternative products less reductions in cost of sales on levalbuterol (Xopenex®). Cost of net revenues as a percentage of net revenue was 38.5% for the nine months ended September 30, 2007 as compared to 33.7% for the comparable period in 2006.

The provision for doubtful accounts for the nine months ended September 30, 2007 totaled \$13.7 million, a \$2.8 million increase from the comparable period in 2006. This increase was mainly attributable to uncollectible deductible amounts from patients, as well as increased revenues. The provision for doubtful accounts was 3.3% for the nine months ended June 30, 2007 as compared to 2.9% for the nine months ended September 30, 2006.

Selling, general and administrative expenses for the nine months ended September 30, 2007 totaled \$224.0 million, a decrease of \$1.3 million or 0.6% from the comparable period in 2006. This decrease in selling, general and administrative expenses is mainly attributable to non-recurring costs expensed during the nine months ended September 30, 2006 related to discussions regarding a potential strategic transaction which were terminated. Selling, general and administrative expenses as a percentage of net revenues decreased to 53.3% for the nine months ended September 30, 2007 from 60.6% for the nine months ended September 30, 2006, primarily as a result of the increase in net revenues during the nine months ended September 30, 2007 as compared to the comparable period in 2006.

Depreciation and amortization for the nine months ended September 30, 2007 totaled \$10.9 million, a decrease of \$2.1 million or 16.4% from the comparable period in 2006. This decrease is mainly the result of decreased capital expenditures on computer and other equipment, as well as certain computer and other equipment becoming fully depreciated during the last twelve months. Depreciation and amortization as a percentage of net revenue decreased to 2.6% as compared to 3.5% for the comparable period in 2006.

We recorded an estimated non-cash goodwill impairment charge of \$529.0 million for the nine months ended September 30, 2006 as the result of an overall decline in our profitability which resulted primarily from decreases in Medicare reimbursement rates, including the reductions for compounded budesonide and the resulting decline in our market capitalization. We did not have any similar impairment charges during the nine months ended September 30, 2007.

Net interest expense for the nine months ended September 30, 2007 totaled \$34.2 million, an increase of \$7.5 million or 28.1% from the comparable period in 2006. The increase is primarily attributable to an increase of approximately \$83.2 million in the average debt outstanding during the nine months ended September 30, 2007 as compared to the comparable period in 2006, as well as an increase of approximately 227 basis points in the average applicable variable interest rates.

We recorded a loss on extinguishment of debt for the nine months ended September 30, 2007 in the amount of \$12.2 million. This amount equals the unamortized debt issuance costs from our September 15, 2006 refinancing, as well as prepayment premiums paid in accordance with the former credit agreement. This amount was written off on March 30, 2007 upon the closing of our new \$180.0 million term loan and repayment of all amounts associated with the former credit facility.

Federal and state income tax benefit for the nine months ended September 30, 2007 decreased to \$4.6 million from \$42.3 million for the comparable period in 2006. This decrease in tax benefit is primarily the result of a decrease in the loss before income taxes and a lower effective tax rate due to the recording of a full valuation allowance against future benefits of current period losses, offset by the expiration of various statutes of limitations and a favorable settlement of an appeal of state income taxes related to 2002.

Net loss for the nine months ended September 30, 2007 was \$31.4 million compared to a net loss of \$517.6 million for the nine months ended September 30, 2006. As outlined above, we recorded three significant accounting adjustments in 2006 that did not recur in 2007. These three adjustments (the \$529.0 million non-cash goodwill impairment charge, the \$17.5 million increase in contractual adjustments, and the \$42.3 million tax benefit) contributed an aggregate of \$504.2 million to the net loss for the nine months ended September 30, 2006. As described above, we recorded a loss on extinguishment of debt which contributed \$12.2 million to the net loss for the nine months ended September 30, 2007.

### **Inflation and Seasonality**

Management believes that there has been no material effect on our operations or financial condition as a result of inflation during the past three fiscal years. However, we are impacted by rising costs for certain inflation-sensitive operating expenses, such as labor and employee benefits, facility and equipment leases, and vehicle fuel. With reductions in reimbursement by government and private medical insurance programs and pressure to contain the costs of such programs, we bear the risk that reimbursement rates set by such programs will not keep pace with inflation. Management also believes that the seasonal impact on our business is not material.

### **Liquidity and Capital Resources**

For the nine months ended September 30, 2007, net cash provided by operating activities was \$45.5 million compared to \$4.0 million for the same period in 2006. Cash flows and cash on hand were sufficient to fund operations, capital expenditures and required repayments of debt during the quarter ended September 30, 2007.

Accounts receivable before allowance for doubtful accounts decreased to \$84.4 million at September 30, 2007 from \$91.2 million at December 31, 2006. Allowances for contractual adjustments and doubtful accounts as a percentage of accounts receivable totaled 32.4% and 34.0% as of September 30, 2007 and December 31, 2006, respectively. Days sales outstanding (calculated as of each period end by dividing net accounts receivable by the 90-day rolling average of net revenue) were 48.8 days at September 30, 2007, compared to 55.7 days at December 31, 2006. The following table sets forth the percentage breakdown of our accounts receivable by payer and aging category as of September 30, 2007 and December 31, 2006:

**September 30, 2007**

<u>Accounts receivable by payer and aging category:</u>	<u>Government</u>	<u>Managed Care and Other</u>	<u>Patient Responsibility</u>	<u>Total</u>
Aged 0-90 days	40.5%	21.1%	3.0%	64.6%
Aged 91-180 days	6.5%	6.4%	2.6%	15.5%
Aged 181 - 360 days	6.6%	5.2%	2.7%	14.5%
Aged over 360 days	3.4%	1.7%	0.3%	5.4%
<b>Total</b>	<b>57.0%</b>	<b>34.4%</b>	<b>8.6%</b>	<b>100.0%</b>

**December 31, 2006**

<u>Accounts receivable by payer and aging category:</u>	<u>Government</u>	<u>Managed Care and Other</u>	<u>Patient Responsibility</u>	<u>Total</u>
Aged 0-90 days	41.1%	14.9%	1.8%	57.8%
Aged 91 - 180 days	7.5%	8.5%	2.0%	18.0%
Aged 181 - 360 days	7.4%	7.6%	2.8%	17.8%
Aged over 360 days	2.2%	3.2%	1.0%	6.4%
<b>Total</b>	<b>58.2%</b>	<b>34.2%</b>	<b>7.6%</b>	<b>100.0%</b>

Included in accounts receivable are earned but unbilled receivables of \$25.4 million at September 30, 2007 and \$26.8 million at December 31, 2006. These amounts include \$4.8 million at September 30, 2007 and \$5.1 million at December 31, 2006 of receivables for which a prior authorization is required but has not yet been received. Delays, ranging from a day 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 the date of service and are considered in our analysis of historical performance and collectibility.

Due to the nature of the industry and the reimbursement environment in which we operate, certain estimates are required to record 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 analyses to evaluate the net realizable value of accounts receivable. Specifically, management considers historical realization data, accounts receivable aging trends, other operating trends and relevant business conditions. Because of continuing changes in the health care industry and third-party reimbursement, it is possible that management's estimates could change, which could have an impact on revenues, profit margins, profitability, operating cash flows and results of operations. For example, for the year ended December 31, 2006, we had \$5.6 million of changes in estimates (increasing contractual adjustments and the provision for doubtful accounts) related to the prior period recorded during the current period.

We derive a significant portion of our revenues from the Medicare and Medicaid programs and from managed care health plans. Payments for services rendered to patients covered by these programs may be less than billed charges. Revenue is recognized at net realizable amounts estimated to be paid by customers and third-party payors. Our billing system contains payor-specific price tables that reflect the fee schedule amounts in effect or contractually agreed upon by various government and commercial payors for each item of equipment or supply provided to a customer. For Medicare and Medicaid revenues, as well as most other managed care and private payors, final payment is subject to administrative review and audit. Management makes estimated provisions for adjustments, which may result from administrative review and audit, based upon historical experience. Management closely monitors its historical collection rates as well as changes in applicable laws, rules and regulations and contract terms to help assure that provisions are made using the most accurate information management believes to be available. However, due to the complexities involved in these estimations, actual payments we receive could be different from the amounts we estimate and record.

Collection of receivables from third party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risks relate to patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. We record bad debt expense based on a percentage of revenue using historical Company-specific data. The percentage and amounts used to record bad debt expense and the allowance for doubtful accounts are supported by various methods including current and historical cash collections, bad debt write-offs, and aging of accounts receivable. Accounts are written off against the allowance when all collection efforts (including payor appeals processes) have been exhausted. We routinely review accounts receivable balances in conjunction with our historical contractual adjustment and bad debt rates and other economic conditions which might ultimately affect the collectibility of patient accounts when we consider the adequacy of the amounts we record as provision for doubtful accounts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental health care coverage could affect our collection of accounts receivable, cash flows and results of operations. We manage billing and collection of accounts receivable through our own billing and collection centers. Further, even if our billing procedures comply with all third-party payor requirements, some of our payors may experience financial difficulties, may delay payments or may otherwise not pay accounts receivable when due, which would result in increased write-offs or provisions for doubtful accounts. For example, CMS placed a hold on payments for all claims under Medicare Parts A and B from all providers and all physicians during the last nine days of the 2006 federal fiscal year (September 22—September 30, 2006). Information is not available to determine the exact impact of this payment hold, however we have estimated that this payment hold resulted in an increase in accounts receivable and a corresponding decrease in cash at September 30, 2006 estimated between \$4.1 million and \$7.7 million. We continue to experience inconsistent payment patterns from CMS and its contractors and other third-party payors. As such, we may not be able to maintain our current levels of collectibility. In addition, third-party payors may experience financial difficulties which could impact their ability to make timely payments to us. If we are unable to collect our accounts receivable on a timely basis, our revenues, profitability and cash flow likely will significantly decline.

Because of continuing changes in the health care industry and third-party reimbursement, it is possible that management's estimates could change, which could have an impact on revenues, profit margins, profitability, operating cash flows and results of operations. Our future liquidity may be materially adversely impacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Net cash used in investing activities was \$50.5 million for the nine months ended September 30, 2007, as compared to \$48.6 million for the same period in 2006. We currently have no contractual commitments for capital expenditures over the next twelve months other than to acquire equipment as needed to supply our patients. Our business requires us to make significant capital expenditures relating to the purchase and maintenance of the medical equipment used in our business. Capital expenditures totaled approximately \$37.5 million for the nine months ended September 30, 2007 as compared to \$46.8 million for the same period in 2006. The decrease in 2007 is primarily attributed to increased utilization rates on rental equipment. We utilized approximately \$13.0 million for the nine months ended September 30, 2007 as cash collateral, including \$12.5 million related to outstanding letters of credit. There were no businesses acquired during the nine months ended September 30, 2007. Cash outlays for businesses acquired totaled \$1.8 million for the nine months ended September 30, 2006.

Cash flows provided by financing activities primarily relate to the refinancing of our former senior secured credit facility. As of September 30, 2007, we had the following debt facilities and outstanding debt:

- \$187.0 million senior secured term loan with a maturity date of September 26, 2011, the proceeds of which were used to repay the outstanding balance under our former term loan and revolving credit facility, pay associated transaction costs, cash collateralize our existing letters of credit and to fund future working capital requirements. As of September 30, 2007, the entire amount of the term loan was outstanding. The term loan bears interest at the Eurodollar rate plus 6.0% (11.4% as of September 30, 2007). As a payment-in-kind term loan facility, accrued interest is added to the principal amount on each interest payment date, provided that we may, at our election, pay any such accrued interest in cash on such date. We have not elected to pay any such accrued interest in cash during the nine months ended September 30, 2007. Accordingly, during the nine months ended September 30, 2007, a total of \$7.0 million in accrued interest has been added to the principal amount on the applicable interest payment dates (representing all accrued interest under the payment-in-kind term loan that became payable during such periods), increasing the principal amount outstanding to \$187.0 million as of September 30, 2007.
- \$300.0 million aggregate principal amount of 9.5% senior subordinated notes, the proceeds of which were used to repay certain pre-petition claims owed to the creditors of our predecessor as part of its plan of reorganization. The notes mature on April 1, 2012. Interest of 9.5% is payable semi-annually in arrears on April 1 and October 1 of each year. As of both September 30, 2007 and December 31, 2006, we had a balance of \$287.0 million outstanding. We made our regularly scheduled April 1 interest payment of \$13.6 million during the nine months ended September 30, 2007 and our regularly scheduled October 1 payment on the date due. Accrued interest on the senior subordinated notes totaled \$13.6 million at September 30, 2007 and \$6.8 at December 31, 2006.

As of December 31, 2006, we had a balance of \$95.0 million outstanding under our former term loan and \$0.3 million of accrued interest. We had no amounts outstanding under our former revolving credit facility; however, we had \$14.1 million committed under standby letters of credit.

During the nine months ended September 30, 2007, we made regularly scheduled amortization payments of \$0.2 million on our former term loan. Interest paid on our former term loans and revolving credit facilities during the nine months ended September 30, 2007 and 2006 was \$2.6 million and \$4.0 million, respectively. As noted above, all amounts payable under our former term loan and revolving credit facility were repaid on March 30, 2007 upon closing of the \$180.0 million senior secured term loan described herein.

On March 30, 2007, we entered into a credit agreement (the "Credit Agreement") with the lenders that are parties thereto (the "Lenders"). Pursuant to the Credit Agreement, the Lenders have provided a payment-in-kind term loan facility in an aggregate principal amount of \$180.0 million (the "Senior Facility"). We used the proceeds of the Senior Facility to (i) repay all amounts due under our former credit agreement dated as of September 15, 2006 and terminated such agreement in connection therewith, (ii) pay associated transaction costs, and (iii) cash collateralize our existing letters of credit. We expect to use the balance of the loan for general working capital purposes. The Senior Facility is scheduled to mature on September 26, 2011 and the obligations thereunder are secured by substantially all of our assets and the assets of our subsidiaries. The interest rate under the Senior Facility is equal to the Base Rate plus 5% or the Eurodollar Rate plus 6% (11.4% as of September 30, 2007). The interest period, at our election, can be one, two, three or six months. Upon each renewable term we have the ability to change the interest period. As a payment-in-kind term loan facility, accrued interest is added to the principal amount on each interest payment date, provided that we may, at our election, pay any such accrued interest in cash on such date.

The Credit Agreement provides for mandatory prepayment upon the occurrence of certain specified events. The Credit Agreement contains customary covenants for financings of this type, including, but not limited to, limitations on dividends on, redemptions and repurchases of, equity interests, limitations on prepayments of junior indebtedness, redemptions and repurchases of debt (other than loans under the Senior Facility), limitations on liens and sale-leaseback transactions, limitations on loans and investments; limitations on debt and guarantees, limitations on mergers, acquisitions and asset sales, limitations on transactions with affiliates, limitations on changes in business conducted by the Company and its subsidiaries, restrictions on ability of subsidiaries to pay dividends or make distributions, limitations on modifications of certain debt and debt instruments, and limitations on capital expenditures. The Credit Agreement also contains a financial covenant which requires us to maintain a specified minimum EBITDA threshold.

The Credit Agreement contains customary events of default. Such events of default include, but are not limited to: (i) the failure to pay principal or interest when due, (ii) the breach or failure to perform certain covenants or obligations and the failure to cure the same within a specified number of days, (iii) material breach of our representations and warranties, (iv) the occurrence of a change of control (as defined in the credit agreement), and (v) the commencement of any proceeding relating to bankruptcy by us or any guarantor. Under certain circumstances, if an event of default occurs and is continuing, payment of amounts due under the credit agreement may be accelerated.

In connection with the Credit Agreement, on March 30, 2007, we also entered into a Guarantee and Collateral Agreement, pursuant to which the obligations thereunder are guaranteed by substantially all of our domestic subsidiaries (the "Subsidiary Guarantors") and the obligations under the new senior facility are secured by substantially all of our assets and the assets of the Subsidiary Guarantors.

We have outstanding letters of credit totaling \$11.9 million as of September 30, 2007, which are cash collateralized at 105% of their face amount. The cash collateral in the amount of \$12.5 million is included in restricted cash in our consolidated balance sheet as of September 30, 2007.

Our working capital requirements relate primarily to the working capital needed for general corporate purposes. Our business requires us to make significant capital expenditures relating to the purchase and maintenance of the medical equipment used in our business. We do not expect to exceed our debt limitations for capital expenditures during the year ended December 31, 2007. Based on current conditions, we believe that the cash generated from our operations and cash balances will be sufficient to meet our working capital, capital expenditure and other cash needs through 2008.

## Off-balance Sheet Arrangements and Contractual Obligations

We do not have off-balance sheet arrangements (as that term is defined in Item 303(a)(4)(ii) of Regulation S-K) that have or are reasonably likely to have a current or future effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources. The following table updates our contractual obligations as of September 30, 2007 to reflect the change in obligations related to our senior secured notes and senior secured term loan due to our new Credit Agreement described above and in Notes 3 and 10 to our condensed consolidated financial statements included in this report. Other than with respect to our new Credit Agreement, there are no material changes with respect to contractual obligations as presented in our Annual Report on Form 10-K for the year ended December 31, 2006.

### Contractual Obligations

	Payments due by period (in thousands)				
	Total	Less than 1 year	1-3 years	3-5 years	More than 5 years
Obligations related to our senior secured notes and senior secured term loan(1)	\$724,802	\$27,265	\$54,530	\$643,007	\$ —

- (1) Our debt is comprised of our \$287 million of 9 1/2% senior secured notes due 2012, our senior secured term loan and related interest charges. See Note 10 to the consolidated financial statements included in this report for a discussion of our long-term debt.

### Critical Accounting Policies

The preparation of our financial statements in accordance with generally accepted accounting principles requires us to make assumptions that affect the reported amounts of assets, liabilities and disclosure of contingencies as of the date of the financial statements, as well as the reported amounts of revenues and expenses during the reporting periods. Critical accounting policies are those that require the most complex or subjective judgments often as a result of the need to make estimates about the effects of matters that are inherently uncertain. Thus, to the extent that actual events differ from our estimates and assumptions, there could be a material impact to our financial statements. We believe that the critical accounting policies for our company are those related to revenue recognition, accounts receivable, goodwill and other intangibles.

The below listing is not intended to be a comprehensive list of all our accounting policies. In many cases, the accounting treatment of a particular transaction is specifically dictated by generally accepted accounting principles with limited or no need for management's judgment. There are also areas in which management's judgment in selecting available alternatives may or may not produce a materially different result. For more information, see our audited consolidated financial statements and notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2006.

#### Revenue Recognition

Revenues are recognized when persuasive evidence of an arrangement exists; delivery has occurred; our price to the buyer is fixed or determinable; and collectibility is reasonably assured.

Our rental arrangements generally provide for fixed monthly payments established by fee schedules for as long as the patient is using the equipment and medical necessity continues (subject to capped rentals which limit the rental payment period in some instances). Once initial delivery is made to the patient (initial setup), a monthly billing is established based on the initial setup service date. We recognize rental arrangement revenues ratably over the monthly service period and defer revenue for the portion of the monthly bill which is unearned. No separate revenue is earned from the initial setup process. We have no lease with the patient or third-party payor. During the rental period we are responsible for providing oxygen refills and for servicing the equipment based on manufacturers' recommendations. Revenues for the sale of durable medical equipment and related supplies, including oxygen equipment, ventilators, wheelchairs, hospital beds and infusion pumps, are recognized at the time of delivery. Revenues for the sale of nebulizer medications, which are generally dispensed by our pharmacies and shipped directly to the patient's home, are recognized at the time of shipment. Revenues derived from capitation arrangements are insignificant.

#### Net Patient Service Revenues

Net patient service revenues are recorded at net realizable amounts estimated to be paid by customers and third-party payors. Our billing system contains payor-specific price tables that reflect the fee schedule amounts, as available, in effect or contractually agreed upon by various government and commercial payors for each item of equipment or supply provided to a customer. Net patient service revenues are recorded based upon the applicable fee schedule.

We track collections and adjustments as a percentage of related revenues. Historical collection and adjustment percentages serve as the basis for our provisions for contractual adjustments and doubtful accounts. The provision for contractual adjustments is recorded as a reduction to net patient service revenues and consists of:

- (1) *Differences between the non-contracted third-party payors' allowable amounts and our usual and customary billing rate.* We do not have contracts or fee schedules with all third-party payors. Accordingly, for non-contracted payors where no fee schedule is available, we record revenue based upon our usual and customary billing rates. Actual adjustments that result from differences between the non-contracted third-party payors' allowable amounts and our usual and customary billing rates are recorded against the allowance for contractual adjustments and are typically identified and recorded at the point of cash application.
- (2) *Services for which payment is denied by governmental or third-party payors, or that we otherwise deem non-billable.* Final payment under governmental programs, and most third-party contracts, is subject to administrative review and audit. Furthermore, the complexity of governmental and third-party billing reimbursement arrangements, including patient qualification and medical necessity requirements, may result in adjustments to amounts originally recorded. Such adjustments may be recorded as the result of the denial of claims billed to governmental or third-party payors, or as the result of our review procedures prior to submission of the claim to the governmental or third-party payor. Actual adjustments that result from services for which payment is denied by governmental or third-party payors, or otherwise deemed non-billable by us are recorded against the allowance for contractual adjustments.

The provision for contractual adjustments reduces amounts recorded through our billing system to estimated net realizable amounts. We record the provision for contractual adjustments based on a percentage of revenue using historical company-specific data. The percentage and amounts used to record the provision for contractual adjustments are supported by various methods including current and historical cash collections, as well as actual contractual adjustment experience. This percentage, which is adjusted at least on an annual basis, has proven to be the best indicator of expected realizable amounts.

We closely monitor our historical contractual adjustment rates, as well as changes in applicable laws, rules and regulations and contract terms to help assure that provisions are made using the most accurate information we believe to be available. Due to the nature of the industry and the reimbursement environment in which we operate, certain estimates are required in order to record net patient service revenues at their net realizable values. Inherent in these estimates is the risk that they may have to be revised or updated as additional information becomes available. Specifically, the complexity of many third-party billing arrangements, patient qualification for medical necessity of equipment 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.

The provision for doubtful accounts is recorded as an operating expense and consists of billed charges that are estimated to be uncollectible due to the patient's or third-party payor's inability or refusal to pay, as described below.

#### *Provision for Doubtful Accounts*

Medicare and most other government and commercial payors that provide coverage to our customers include a 20 percent co-payment provision in addition to a nominal deductible. Co-payments are generally not collected at the time of service and are invoiced to the customer or applicable secondary payor (supplemental providers of insurance coverage) on a monthly billing cycle as products are provided. A majority of our customers maintain, or are entitled to, secondary or supplemental insurance benefits providing "gap" coverage of this co-payment amount. In the event coverage is denied by the third-party payor, the customer is ultimately responsible for payment of charges for all services rendered by us.

Collection of receivables from third party payors and patients is our primary source of cash and is critical to our operating performance. Our primary collection risk, with regard to doubtful accounts, relates to patient accounts for which the primary insurance payor has paid, but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. We record a provision for doubtful accounts based on a percentage of revenue using historical company-specific data. The percentage and amounts used to record the provision for doubtful accounts are supported by various methods including current and historical cash collections, actual write-offs, and accounts receivable agings. Accounts are written off against the allowance for doubtful accounts when all collection efforts have been exhausted. We routinely review accounts receivable balances in conjunction with our historical bad debt rates and other economic conditions which might ultimately affect the collectibility of patient accounts when we consider the adequacy of the amounts we record as provision for doubtful accounts. Significant changes in payor mix, economic conditions or trends in federal and state governmental health care coverage could affect our collection of accounts receivable, cash flows and results of operations.

### *Accounts Receivable, net*

Accounts receivable are presented net of allowances for contractual adjustments and doubtful accounts. Allowances for contractual adjustments and doubtful accounts are initially recorded based upon historical collection experience through the provisions for contractual adjustment and doubtful accounts, as described above. If the payment amount received differs from the net realizable amount, an adjustment is made to the net realizable amount in the period that these payment differences are determined. Actual accounts receivable write-offs due to contractual adjustments or accounts deemed uncollectible are applied against these allowance accounts in the normal course of business. On a quarterly basis, we perform analyses to evaluate the estimated net realizable value of accounts receivable. As a result of this quarterly review process, the allowances for contractual adjustments and doubtful accounts are adjusted, as necessary, to reflect that estimated net realizable value. Specifically, we consider historical collection data, accounts receivable aging trends, other operating trends and relevant business conditions.

Due to the nature of the industry and the reimbursement environment in which we operate, certain estimates are required in order to record net revenues and accounts receivable at their net realizable values. Inherent in these estimates is the risk that they may have to be revised or updated as additional information becomes available. It is possible that management's estimates could change, which could have an impact on revenues, profit margins, profitability, operating cash flows and results of operations. For example, a 1% decline in the overall collection rate would reduce net patient service revenue and associated net accounts receivable by \$6.0 million (based upon \$600.0 million in annual gross patient service revenue). Additionally, the complexity of many third-party billing arrangements, patient qualification for medical necessity of equipment and the uncertainty of reimbursement amounts for certain services from certain payors may result in adjustments to amounts originally recorded.

### *Reorganization Value in Excess of Value of Identifiable Assets—Goodwill and Intangible Assets*

Reorganization value in excess of value of identifiable assets—goodwill, represents the portion of our reorganization value at March 26, 2002 that could not be attributed to specific tangible or identified intangible assets recorded in connection with the implementation of fresh-start reporting. These amounts are not amortized, but instead tested for impairment in accordance with the provisions of Financial Accounting Standards Board (FASB) Statement No. 142, *Goodwill and Other Intangible Assets*. To the extent the carrying amount of reporting unit goodwill is greater than the implied fair value of reporting unit goodwill, we would record an impairment charge for the difference. Fair values for goodwill and intangible assets are determined based upon discounted cash flows, market multiples or appraised values as appropriate. Our branch locations have similar economic characteristics and are aggregated into one reporting unit for assessing fair value. The impairment evaluation for goodwill and other intangible assets is conducted annually, or more frequently, if events or changes in circumstances indicate that an asset might be impaired.

We account for our business combinations in accordance with the purchase method of accounting. Purchase prices are allocated to the various underlying tangible and intangible assets and liabilities on the basis of estimated fair value. The fair value of acquired finite-lived identifiable intangible assets is amortized over the period of their expected useful life, generally 2 to 20 years.

### *Property and Equipment*

Property and equipment are stated at cost, adjusted for the impact of fresh start reporting. Patient service equipment represents medical equipment rented or held for rental to in-home patients. Patient service equipment is accounted for using a composite method, due to its characteristics of high unit volumes of relative low dollar unit cost items. Under the composite method, the purchase cost of monthly purchases of certain patient service equipment are capitalized and depreciated over five years using the straight-line convention, without specific physical tracking of individual items. We believe the five year depreciation period provides a proper matching of the cost of patient service equipment with the patient service revenues generated from use of the equipment, when considering the wear and tear, damage, loss and ultimately scrapping of patient service equipment over its life. Other property and equipment is accounted for by a specific identification system. Depreciation for other property and equipment is provided on the straight-line method over the estimated useful lives of the assets, seven years for furniture and office equipment, five years for vehicles, three years for computer equipment, and the shorter of the remaining lease term or the estimated useful life for leasehold improvements.

### *Capitalized Software*

Included in property and equipment are costs related to internally-developed and purchased software that are capitalized and amortized over periods from three to fifteen years. Capitalized costs include direct costs of materials and services incurred in developing or obtaining internal-use software and payroll and payroll-related costs for employees directly involved in the development of internal-use software. The carrying value of capitalized software is reviewed if the facts and

circumstances suggest that it may be impaired. Indicators of impairment may include a subsequent change in the extent or manner in which the software is used or expected to be used, a significant change to the software is made or expected to be made or the cost to develop or modify internal-use software exceeds that expected amount.

### *Income Taxes*

In connection with our predecessor's (Rotech Medical Corporation) plan of reorganization (the "Plan"), we entered into a tax sharing agreement with our predecessor and Integrated Health Services, Inc. that sets forth our rights and obligations with respect to taxes arising from and in connection with the implementation of the Plan. The tax sharing agreement provides that the parties to the agreement will, for tax purposes, treat the transfer of our predecessor's assets to us as a taxable event rather than as a tax-free reorganization. An election was made under Section 338(h)(10) of the Internal Revenue Code of 1986, as amended, and under analogous state and local law, with respect to the transfer of our predecessor's assets to us. As a result of such election, we accounted for the acquisition of the stock of all of our predecessor's subsidiaries as if we had acquired the assets of those subsidiaries for income tax purposes.

We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are determined based upon differences between financial reporting and the tax bases of assets and liabilities and are measured using the enacted tax rates and laws that will be in effect when the differences are expected to reverse. Valuation allowances are established when necessary to reduce deferred income tax assets to amounts expected to be realized.

Net operating loss carryforwards and credits (NOLs) are subject to review and possible adjustments by the Internal Revenue Service and may be limited by the occurrence of certain events, including significant changes in ownership interests. The effect of an ownership change would be the imposition of an annual limitation on the use of the NOL carryforwards attributable to periods before the change. We regularly monitor changes in ownership and any implications thereof under Section 382 of the Internal Revenue Code.

On January 1, 2007, we implemented the provisions of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes* ("FIN 48"). FIN 48 clarifies the accounting for uncertainty in income taxes and prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This adoption did not have a material impact on our financial position.

### *Contingencies*

Our business is subject to extensive laws and government regulations, including those related to the Medicare and Medicaid programs. We are also subject to a Corporate Integrity Agreement with the DHHS. Non-compliance with such laws and regulations or the Corporate Integrity Agreement could subject us to severe sanctions, including penalties and fines.

FASB Statement No. 5, *Accounting for Contingencies*, provides guidance on the application of generally accepted accounting principles related to these matters. We evaluate and record liabilities for contingencies based on known claims and legal actions when it is probable a liability has been incurred and the liability can be reasonably estimated. We believe that our accrued liabilities related to such contingencies are appropriate and in accordance with generally accepted accounting principles.

### **Forward-Looking Statements**

This report contains certain statements that constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 and the provisions of section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and section 27A of the Securities Act of 1933, as amended. These forward-looking statements include all statements regarding the intent, belief or current expectations regarding the matters discussed in this report and all statements which are not statements of historical fact. Words such as "expects," "anticipates," "intends," "plans," "believes," "estimates," "projects," "may," "will", "could", "should", "would", variations of such words and similar expressions are intended to identify such forward-looking statements. These forward-looking statements involve known and unknown risks, uncertainties, contingencies and other factors that could cause results, performance or achievements to differ materially from those stated in this report. The following are some but not all of such risks, uncertainties, contingencies, assumptions and other factors, many of which are beyond our control, that could cause results, performance or achievements to differ materially from those anticipated: general economic, financial and business conditions; changes in reimbursement policies, the timing of reimbursements and other legislative initiatives aimed at reducing health care costs associated with Medicare and Medicaid, including, without limitation, the impact of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and the uncertainties relating to inhalation drug reimbursement; issues relating to reimbursement by government and third party payors for our products and services generally; the costs associated with government regulation of the health care industry; health care reform and the effect of changes in federal and state health care regulations generally; whether we

will be subject to enforcement action or other negative actions in connection with the FDA's warning letter; whether we will be subject to additional regulatory restrictions or penalties; issues relating to our ability to maintain effective internal control over financial reporting and disclosure controls and procedures; compliance with confidentiality requirements with respect to patient information; the effects of competition and industry consolidation; compliance with various settlement agreements and corporate compliance programs that we have established; risks related to acquired businesses; the costs and effects of legal proceedings; the risks and uncertainties discussed under the heading "Certain Significant Risks and Uncertainties and Significant Events" in Note 9 of the Condensed Consolidated Financial Statements in Part I, Item 1 of this Form 10-Q and other factors described in our filings with the Securities and Exchange Commission. Readers should refer to the discussion under "Risk Factors" in Part II, Item 1A of this Form 10-Q and contained in our Annual Report on Form 10-K for the year ended December 31, 2006 for a description of additional risks and uncertainties. Should one or more of these risks or uncertainties materialize or should underlying assumptions prove incorrect, our actual results, performance or achievements could differ materially from those expressed in, or implied by, such forward-looking statements. Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date thereof. When you consider these forward-looking statements, you should keep in mind these risk factors and other cautionary statements. We do not undertake any obligation to release any revisions to these forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

### **ITEM 3—Quantitative and Qualitative Disclosures about Market Risk**

As of September 30, 2007, we have one outstanding debt instrument bearing interest at a variable rate. Our current senior secured term loan bears interest equal to the Eurodollar Rate plus 6.0% (or Base Rate plus 5%). Our earnings may be affected by changes in interest rates relating to this debt, as variable interest rates may rise and increase the amount of our interest expense. Assuming a hypothetical increase of one percentage point for the variable interest rate applicable to the \$187.0 million outstanding balance on the term loan, we would incur approximately \$1.9 million in additional interest expense on an annualized basis.

### **ITEM 4—Controls and Procedures**

#### **Disclosure Controls and Procedures**

Our management, with the participation of our principal executive officer and principal financial officer, has evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) as of the end of the period covered by this Quarterly Report on Form 10-Q. Based on such evaluation, our principal executive officer and principal financial officer have concluded, as of the end of such period, that our disclosure controls and procedures are effective.

#### **Changes in Internal Control over Financial Reporting**

We evaluate our internal control over financial reporting on a regular basis. If we identify a problem in our internal control over financial reporting during the course of our evaluations, we consider what revision, improvement and/or correction to make in order to ensure that our internal controls are effective. Our management recognizes that any set of controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives. Accordingly, we intend to continue to refine our internal control over financial reporting on an ongoing basis as we deem appropriate with a view towards making improvements.

We have made no changes during the third quarter of fiscal year 2007 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

## **PART II—OTHER INFORMATION**

### **ITEM 1—Legal Proceedings**

Information required for Part II, Item 1 is incorporated herein by reference to the discussion under the heading "Certain Significant Risks and Uncertainties and Significant Events" in Note 9 of the Condensed Consolidated Financial Statements in Part I, Item 1 of this Form 10-Q.

### **ITEM 1A—Risk Factors**

Except with respect to the risk factors set forth below, there have been no material changes from the risk factors previously disclosed in the Company's Annual Report on Form 10-K for the year ended December 31, 2006, the Company's Quarterly Report on Form 10-Q/A for the quarter ended March 31, 2007, and the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007.

## **Risks related to our liquidity and our financing and capital structures**

### ***We have substantial outstanding indebtedness, which could adversely affect our financial condition.***

As of September 30, 2007, our total consolidated long-term debt (including current maturities) accounted for approximately 98% of our total capitalization. The degree to which we are leveraged could have substantial negative consequences, because:

- it could affect our ability to satisfy our obligations under our 9.5% senior subordinated notes due 2012, including our ability and our decision to make interest payments thereunder when due and payable;
- a substantial portion of our cash flow from operations is required to be dedicated to interest and principal payments and therefore would not be available for operations, working capital, capital expenditures, expansion, acquisitions or general corporate or other purposes;
- our existing credit agreement limits our ability to acquire businesses and incur indebtedness required to finance such acquisitions;
- our ability to finance and consummate transactions that may be critical to our strategic and financial condition could be limited;
- our ability to obtain additional financing in the future may be impaired;
- we are more highly leveraged than some of our competitors, which places us at a competitive disadvantage;
- it makes us more vulnerable in the event of a downturn in our business, our industry, or the economy in general;
- our flexibility in planning for, or reacting to, changes in our business and industry may be limited; and
- we are vulnerable to interest rate fluctuations because a portion of our debt is subject to variable interest rates.

In addition, because our current term loan is a payment-in-kind term loan facility, accrued interest is added to the principal amount on each interest payment date, provided that we may, at our election, pay any such accrued interest in cash on such date. We have not elected to pay any such accrued interest in cash during the nine months ended September 30, 2007. Accordingly, during the three and nine months ended September 30, 2007, \$5.2 million and \$7.0 million, respectively, in accrued interest has been added to the principal amount on the applicable interest payment dates (representing all accrued interest under the payment-in-kind term loan that became payable during such periods), increasing the principal amount outstanding to \$187.0 million as of September 30, 2007. Our ability to make payments on and to refinance our debt will depend on our ability to generate cash in the future. This, to a certain extent, is subject to general economic, business, financial, competitive, legislative, regulatory and other factors that are beyond our control. We may need to refinance all or a portion of our debt, on or before maturity. We may not be able to refinance any of our debt, including our credit facility and our senior subordinated notes, on commercially reasonable terms or at all in which case we may be required to consider all of our alternatives in restructuring our business and our capital structure including filing for bankruptcy protection.

## **Risks related to our reliance on Medicare, Medicaid and other third-party reimbursement**

### ***A substantial percentage of our business is derived from the sale of Medicare-covered HME items, including oxygen, and laws and policies currently in effect reduce payment amounts for certain categories of HME, including those of many of our products.***

Currently, Medicare payments to us for our HME products generally are based on the lesser of the actual charge for the item or the applicable Medicare fee schedule amount. Under the MMA, from 2004 through 2008, most payments for HME are frozen at the 2003 level unless the item becomes subject to further reductions based on Federal Employee Health Benefits Program median payment amounts (as described below), or is subject to competitive bidding. As of January 1, 2005, the fee schedule amounts for certain items of HME, including wheelchairs and nebulizers, were reduced based on the percentage difference between the amount of payment otherwise determined for 2002 and the median amount of payment under the Federal Employee Health Benefits Program, or FEHBP, as determined by the Office of Inspector General of DHHS, or OIG. The FEHBP adjusted payments are to remain “frozen” through 2008 unless the particular item becomes subject to competitive bidding. The fee schedule amounts for oxygen and oxygen equipment were also reduced based on this calculation.

The non-oxygen HME items subject to the Medicare price cuts accounted for approximately 4.1% of our recorded revenues in 2006. Furthermore, the reductions in the Medicare fee schedules for home oxygen equipment together with the additional reimbursement reductions mandated by the MMA in 2005 for other home medical equipment (excluding inhalation drugs) resulted in an aggregate reduction in our 2006 recorded revenues in the amount of approximately \$17.9 million. We cannot predict the outcome of any future rulemaking by CMS. Any additional reductions in Medicare reimbursement rates for home oxygen equipment could have a material adverse effect on our revenues, profitability and results of operations.

The Deficit Reduction Act of 2005, or DRA, which was signed into law on February 8, 2006, also has made certain changes to the way Medicare Part B pays for our HME products, including capped rental items and oxygen equipment. For capped rental items, including hospital beds, nebulizers and power wheelchairs, Medicare has in the past paid a monthly rental fee for a period not to exceed 15 months of continuous use. Under the DRA, the maximum number of months for which Medicare is to make payment for such equipment decreased from 15 months to 13 months of continuous use, after which time ownership is automatically transferred to the beneficiary. This provision is effective for items furnished for which the first rental month is during or after January 2006. As to power wheelchairs, the DRA preserves an existing provision requiring that beneficiaries be given the option to purchase the power wheelchair at the time it is furnished. For oxygen equipment, prior to the DRA, Medicare made monthly rental payments indefinitely, provided medical need continued. The DRA capped the Medicare rental period for oxygen equipment at 36 months of continuous use, after which time ownership of the equipment transfers to the beneficiary. For purposes of this cap, the DRA provides for a new 36 month rental period that began January 1, 2006 for all oxygen equipment. This new 36 month rental period applies for beneficiaries starting to use the equipment as well as for those who have been using it prior to 2006. In addition to the changes in the duration of the rental period for capped rental items and oxygen equipment, the DRA authorizes payments for servicing and maintenance of the products after ownership transfers to the beneficiary if the Secretary of the Department of Health and Human Services determines the servicing and maintenance is reasonable and necessary. Prior to the changes by the DRA to the duration of the capped rental period and the new transfer of ownership requirement, Medicare payment for the capped rental items was made automatically every six months for servicing and maintenance for those products for which a Medicare supplier retained ownership after the capped rental period ended.

On November 1, 2006, CMS released a final rule to implement the DRA changes, which went into effect January 1, 2007. Under the rule, CMS explains the DRA's 36-month rental cap on oxygen equipment that began on January 1, 2006. CMS also revised categories and payment amounts for the oxygen equipment and contents during the rental period and for oxygen contents after equipment ownership by the beneficiary as follows:

- *Payment for Rental Period.* For stationary oxygen equipment, the 2007 payment amount is \$198.40, a decrease of \$1.44 from the 2006 amount. The portable oxygen add-on amount remains unchanged from 2006, at \$31.79. CMS also created a new class for oxygen-generating portable oxygen equipment and a new monthly rental payment amount of \$51.63 for this equipment.
- *Payment for Contents After Beneficiary Ownership.* Payment is based on the type of equipment owned and whether it is oxygen-generating. Previously, CMS paid a combined average monthly payment amount of \$154.90 for furnishing oxygen contents for beneficiary-owned stationary and portable systems. This amount included payment for both stationary contents and portable contents. CMS will split this payment into a separate monthly payment amount for stationary oxygen content of \$77.45 and a separate monthly payment amount for portable oxygen content of \$77.45. This payment amount is for oxygen contents for equipment that is not oxygen-generating. If the beneficiary owns both stationary and portable equipment that is not oxygen-generating, the monthly payment amount for oxygen contents is \$154.90. For stationary or portable oxygen equipment that is oxygen-generating, there will be no monthly payment for contents.

In its November 1, 2006 final rule, CMS also acknowledges certain other payments after ownership transfers, including payment for supplies such as tubing and masks. In addition, CMS details several requirements regarding a supplier's responsibility to maintain and service capped rental items and provides for a general maintenance and servicing payment for certain oxygen-generating equipment beginning six months after title has transferred to the beneficiary. While we do not expect the changes in rental periods and payment amounts for capped rental items and oxygen equipment to have a material impact on our business in 2007, at this time, we anticipate that the changes in rental period for capped rental items and oxygen equipment will have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations beginning in 2009. We cannot predict the impact that any future rulemaking by CMS will have on our business. If payment amounts for oxygen equipment and contents are further reduced in the future, this could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

President George W. Bush's proposed 2008 budget includes a further reduction in the maximum rental period for home oxygen equipment from 36 months to 13 months. Additionally, on August 1, 2007, the U.S. House of Representatives passed H.R. 3162, "The Children's Health and Medicare Protection Act." This legislation would reduce payments to Medicare Advantage plans and increase the federal cigarette tax by 45 cents per pack to increase funding for the State Children's Health Insurance Program (SCHIP) by \$50 billion over five years. This legislation also would reduce the oxygen equipment rental cap from 36 months to 18 months. On August 2, 2007, the U.S. Senate passed S 1893. This legislation would reauthorize SCHIP and increase the cigarette tax by 61 cents per pack to fund a SCHIP expansion of \$35 billion over 5 years. As passed by both the House and Senate, the SCHIP legislation did not contain the proposed provisions affecting oxygen equipment providers. In addition,

the President vetoed the SCHIP legislation on October 3, 2007, and the U.S. House of Representatives failed to override the President's veto. Provisions impacting oxygen reimbursement may be reintroduced in future legislation. However, we cannot predict what changes would be made to existing or proposed legislation and are therefore unable to estimate at this time the impact future legislation would have on our business.

***Federal law establishing a competitive bidding process under Medicare could negatively affect our business and financial condition.***

On April 2, 2007, CMS released its final rule implementing a competitive bidding program for certain HME products under Medicare Part B. This nationwide competitive bidding program is designed to replace the existing fee schedule payment methodology. Under competitive bidding, suppliers compete for the right to provide items to beneficiaries in a defined region. CMS will select contract suppliers that agree to receive as payment the "single payment amount" calculated by the agency after bids are submitted. The deadline for submitting bids was September 25, 2007, and we submitted our bids on July 19, 2007 for the first round of competitive bidding for each of the respective metropolitan statistical areas, or MSAs, and product categories in which we intend to participate. CMS is scheduled to conclude bid evaluation and begin the contracting process in January 2008. CMS will announce winning suppliers for the first round in March 2008 and conduct intensive beneficiary and referral agent education from April 1, 2008 to July 1, 2008. The effective date for the first round of the program is now scheduled to begin on July 1, 2008. Selected suppliers must agree to offer each item in product categories selected under the program at the single payment amount.

The competitive bidding program is scheduled to begin in 2008 in ten high-population MSAs, expanding to 80 MSAs in 2009 and additional areas thereafter. In connection with the selection of MSAs, CMS designates by zip code specific areas in which competitive bidding will take place. These areas are referred to as competitive bidding areas or CBAs and may not be congruent with the boundaries of selected MSAs. Only a limited number of suppliers will be selected in any given CBA, resulting in restricted supplier choices for beneficiaries. MMA permits certain exemptions from competitive bidding, including exemptions for rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail-order for the particular item. A large number of our facilities are located in such areas. In its final rule, CMS indicates that it will determine whether to exempt from the competitive bidding program rural areas and areas with low population density within urban areas that are not competitive by examining low utilization (in terms of number of items or allowed charges for those items), low Medicare fee-for-service population, and/or low number of suppliers. The impact of such an exemption on our business remains uncertain.

In a press release issued on the same date as the final rule, CMS announced the first ten MSAs for 2007 and the product categories selected for the first round of bidding. The MSAs include Charlotte-Gastonia-Concord, North Carolina-South Carolina; Cincinnati-Middletown, Ohio-Kentucky-Indiana; Cleveland-Elyria-Mentor, Ohio; Dallas-Fort Worth-Arlington, Texas; Kansas City, Missouri-Kansas; Miami-Fort Lauderdale-Miami Beach, Florida; Orlando, Florida; Pittsburgh, Pennsylvania; Riverside-San Bernardino-Ontario, California; and San Juan-Caguas-Guaynabo, Puerto Rico. We currently operate in nine of these ten MSAs. Suppliers do not need to be physically located in the CBA to submit a bid. The following product categories (all of which we offer for rent or sale), among others, will be subject to competitive bidding in 2007: oxygen supplies and equipment; continuous positive airway pressure, or CPAP, devices, respiratory assist devices or RADs, and related supplies and accessories; standard power wheelchairs, scooters, and related accessories; hospital beds and related accessories; and walkers and related accessories. Each product category subject to competitive bidding is comprised of individual HCPCS codes. To bid on a product, a supplier (or a network of small suppliers) must submit bids on the full spectrum of HCPCS codes contained in that product's category. In addition, commonly-owned suppliers may submit only one bid. Once bids are submitted, CMS determines the composite bid for each product category and arrays them from highest to lowest to select a "pivotal bid" at the point where the expected combined capacity of the bidders is sufficient to meet expected beneficiary demand for items in a category. CMS will award at least five contracts in each CBA, however, if there are less than five suppliers bidding then at least two contract suppliers must be selected for each CBA.

In its final rule, CMS also adopts its proposal to grandfather rental agreements between beneficiaries and non-contract suppliers that pre-date the competitive bidding program in a CBA. A supplier that furnishes certain equipment on a rental basis to a beneficiary prior to the implementation of competitive bidding in a CBA can choose to continue furnishing the item as a grandfathered supplier, without participating in the competitive bidding process. Payment for grandfathered items furnished during the initial phase of the competitive bidding program implemented in a specific CBA will be as follows: capped rental items will be paid the applicable fee schedule amount paid in areas not subject to competitive bidding; and oxygen and oxygen equipment will be paid the single payment amount, which is the payment rate under the competitive bidding program for the CBA. During future rounds of competitive bidding, all grandfathered items will receive the single payment amount.

Under its final rule, if the grandfathering option is not exercised, CMS will require contract suppliers to assume existing rental agreements from non-contract suppliers. Contract suppliers furnishing oxygen equipment will be guaranteed a minimum of ten months of rental payments. For instance, a contractor who assumes a rental agreement for oxygen in month 11 will receive the single payment rate for the remaining 25 months of rental and title transfers to the beneficiary after month 36. A contractor who assumes a rental agreement in month 30, however, nonetheless will receive 10 months of rental payments even though this results in more than a total of 36 months of payment before title transfers. Suppliers who assume agreements for capped rental items will receive at least 13 months of rental payments, or the full rental period, regardless of when the rental agreement is assumed. In addition, CMS had proposed to require contract suppliers to repair or replace patient-owned items subject to competitive bidding, but in response to concerns that contract suppliers should not have to offer repairs for equipment never stocked, CMS will pay for the maintenance and servicing, including replacement parts, of competitively bid items that are performed by any supplier, not just contract suppliers. As to replacements, however, CMS will require that beneficiaries obtain replacements for entire items from contract suppliers.

Until such time that the bids are awarded and the associated fee schedules and participating providers are announced, we will not be able to determine the impact of the final rule, nor can we predict the effect the process will have on our ability to continue to provide products to Medicare beneficiaries.

***Regulatory and other policy changes subject the Medicare reimbursement rates for our equipment and services to potential discretionary adjustment by the Centers for Medicare and Medicaid Services.***

The Balanced Budget Act of 1997, or BBA 97, granted authority to the Secretary of the Department of Health and Human Services, or DHHS, to increase or reduce the reimbursement for home medical equipment, including oxygen, by up to 15% each year under an inherent reasonableness procedure. The final rule implementing the inherent reasonableness authority establishes a process for adjusting payments for certain items and services covered by Medicare Part B when the existing payment amount is determined to be grossly excessive or deficient. The regulation lists factors that may be used by CMS and its contractors to determine whether an existing reimbursement rate is grossly excessive or deficient and to determine what a realistic and equitable payment amount is. Also, under the regulation, CMS and its contractors will not consider a payment amount to be grossly excessive or deficient and make an adjustment if they determine that an overall payment adjustment of less than 15% is necessary to produce a realistic and equitable payment amount.

In addition to its inherent reasonableness authority, CMS has the discretion to reduce the reimbursement for home medical equipment to an amount based on the payment amount for the least costly alternative treatment that meets the Medicare beneficiary's medical needs. Least costly alternative, or LCA, determinations may be applied to particular products and services by CMS and its contractors through the informal notice and comment process used in establishing local coverage policies for HME. This process need not be followed for LCA determinations made on individual claims. Using either its inherent reasonableness or least costly alternative authority, CMS and its contractors may reduce reimbursement levels for certain items and services covered by Medicare Part B, including products and services we offer, which could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

Effective July 1, 2007, CMS also revised its billing codes for non-compounded albuterol and levalbuterol. Under CMS's revised policy, the existing HCPCS codes for these products are no longer permitted to be used for Medicare claims. Instead, two new HCPCS codes were established; new code Q4093 is to be used for claims for the concentrated formulation of both albuterol and levalbuterol, and new code Q4094 is to be used for claims for the single dose form of both albuterol and levalbuterol. CMS has set payment levels for the new HCPCS codes based on the weighted average of the average sales prices, or ASPs, for each product assigned to the respective codes. The 2007 payment rates for concentrated albuterol and concentrated levalbuterol are as follows:

<b>Medicare payment rates effective:</b>	<b>Concentrated Albuterol (1mg)</b>	<b>Concentrated Levalbuterol (.5mg)</b>	<b>Single Dose Albuterol</b>	<b>Single Dose Levalbuterol</b>
1/1/2007 – 3/31/2007	\$ 0.071	\$ 0.989	\$ 0.163	\$ 3.478
4/1/2007 – 6/30/2007	\$ 0.071	\$ 0.922	\$ 0.203	\$ 3.838
7/1/2007 – 9/30/2007	\$ 0.127	\$ 0.127	\$ 1.313	\$ 1.313
10/1/2007 – 12/31/2007	\$ 0.131	\$ 0.131	\$ 1.048	\$ 1.048

To date, the reductions in payment rates for single dose levalbuterol have been offset by reductions in cost of sales for single dose levalbuterol and by increased payment rates for single dose albuterol. However, we expect that future decreases for single dose albuterol and levalbuterol claims could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. At this time, the full effect of the coding and payment revisions on our revenues, profit margins, profitability, operating cash flows and results of operations remains uncertain.

In March 2006, Medicare contractors issued a draft local coverage determination, or LCD, for nebulizers and inhalation drugs dispensed through nebulizers that are covered by Medicare Part B, which proposes to change significantly the payment rates and coverage criteria for several inhalation drugs that we dispense to beneficiaries, in part using the LCA mechanism discussed above. Specifically, the draft LCD proposed to reduce the payment amount for two FDA-approved drugs. The formulation of levalbuterol (commercially available under the name “Xopenex<sup>®</sup>”) would be reduced to the maximum allowable payment for generic albuterol, and the payment amount for the commercially available combination of albuterol and ipratropium (commercially available under the name “DuoNeb<sup>®</sup>”) to the maximum allowable payment for separate unit dose vials of albuterol and ipratropium. In March 2007, the final LCD was issued, removing coverage for compounded nebulizer formulations. The LCD did not change existing coverage for Xopenex<sup>®</sup> or DuoNeb<sup>®</sup>. Instead, the Medicare contractors deferred rendering a final decision on these two drugs until CMS completed its pending national coverage analysis. CMS initiated the national coverage analysis in December 2006 to evaluate Medicare coverage at the national level for beta adrenergic agonist therapy drugs used for lung diseases. As part of the national coverage analysis process, on June 20, 2007, CMS released a proposed decision memorandum which concluded that CMS has insufficient information based on published medical evidence to define specific patient populations who would benefit from a particular treatment with particular medications. As a result, CMS announced in its proposed decision memorandum that it would not issue a national coverage decision and instead would leave to CMS contractors to render local decisions regarding coverage for nebulized beta adrenergic agonist therapy for lung diseases either through an LCD or through claim reviews on a case-by-case basis. This means, for example, if CMS does not otherwise issue a national coverage decision, its Medicare contractors could require the pricing of DuoNeb<sup>®</sup> to be set based on an LCA analysis at the maximum allowable payments for separate unit dose vials of its component drugs, albuterol and ipratropium, which could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. In addition, the introduction into the marketplace of generic alternatives for DuoNeb<sup>®</sup> could result in a decreased ASP and a corresponding decreased Medicare payment rate for the commercially-available combination product. However, at this time, we cannot predict the full impact of such a decrease in ASP or the full impact of an LCA analysis or CMS’s proposed decision memorandum on our revenues, profit margins, profitability, operating cash flows and results of operations.

On August 1, 2007, CMS published a proposed rule that would require all HME suppliers, except those that are government-operated, to obtain and furnish a surety bond to the National Supplier Clearinghouse, the Medicare contractor responsible for enrollment, for each Medicare supplier number held. CMS previously issued a proposed surety bond requirement in 1998 to implement BBA 97. At that time, the proposed surety bond amount was \$50,000; CMS has adjusted the proposed surety bond amount to \$65,000 to reflect inflation. CMS seeks public comments on, among other things, whether the surety bond amount should be increased for so-called “higher-risk” suppliers and whether to establish an exception to the requirement for publicly traded chain suppliers. It is unclear whether the proposal would exempt publicly traded chain suppliers of HME, or whether we would be made subject to such an exemption. If this proposal were enacted and if no such exemption is included, or if we were otherwise not subject to such an exemption, we would be required to obtain surety bonds for each of our approximately 500 locations, resulting in significant additional cost in operating our business.

**If we do not maintain compliance with the listing requirements of the Nasdaq Global Market, our common stock could be delisted by the Nasdaq Global Market, which could, among other things, adversely affect the price and liquidity of our common stock.**

Our common stock is listed on the Nasdaq Global Market. In order to maintain that listing, we must satisfy minimum financial and other standards, including a rule that requires that the minimum bid price per share for our common stock not be less than \$1.00 for 30 consecutive trading days and a rule that requires us to maintain a market value of publicly held shares (exclusive of 10% stockholders) of \$15 million. Given the recent price levels for our common stock, we cannot assure that we will be able to continue to comply with such rules. If we fail to comply and cannot remedy our noncompliance during any applicable notice or grace periods, our common stock could be delisted from the NASDAQ Global Market. The delisting of our common stock would likely have a material adverse effect on the trading price, volume and marketability of our common stock. Upon a delisting from the NASDAQ Global Market, our common stock would become subject to the penny stock rules of the SEC, in which event it is possible that the price of our common stock would further decline and likely that our stockholders would find it more difficult to sell their shares.

**ITEM 2—Unregistered Sales of Equity Securities and Use of Proceeds**

Not applicable.

**ITEM 3—Defaults Upon Senior Securities**

Not applicable.

**ITEM 4—Submission of Matters to a Vote of Security Holders**

Not applicable.

**ITEM 5—Other Information**

Not applicable.

**ITEM 6—Exhibits**

(a) Exhibits:

- 12.1 Ratio of Earnings to Fixed Charges.
- 31.1 Certification of principal executive officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
- 31.2 Certification of principal financial officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
- 32.1 Certification of Chief Executive Officer and Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.



## Exhibit Index

<u>Exhibit No.</u>	<u>Description</u>
12.1	Ratio of Earnings to Fixed Charges.
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**Ratio of Earnings to Fixed Charges**  
**Rotech Healthcare Inc.**  
(In thousands)

	Nine months Ended September 30, 2007	2006	2005	2004	2003
<b><i>Ratio of Earnings to fixed charges</i></b>					
Pretax (loss) earnings from continuing operations	\$ (31,397)	\$(572,907)	\$ 9,159	\$ 63,574	\$15,338
Add:					
Fixed charges	42,952	46,178	41,039	41,253	49,999
Total Earnings (Loss) (A)	<u>\$ 11,555</u>	<u>\$(526,729)</u>	<u>\$50,198</u>	<u>\$104,827</u>	<u>\$65,337</u>
Interest Expense	\$ 35,765	\$ 36,907	\$32,694	\$ 33,967	\$41,884
Estimate of the interest within rental expense	7,187	9,271	8,345	7,286	8,115
Total Fixed Charges (B)	<u>\$ 42,952</u>	<u>\$ 46,178</u>	<u>\$41,039</u>	<u>\$ 41,253</u>	<u>\$49,999</u>
Ratio (A/B)	<u>0.27x</u>	<u>(11.41)x<sup>1</sup></u>	<u>1.22x</u>	<u>2.54x</u>	<u>1.31x</u>

<sup>1</sup> Earnings for the year ended December 31, 2006 were inadequate to cover fixed charges. The coverage deficiency was \$572,907.

**CERTIFICATION**

I, Philip L. Carter, certify that:

1. I have reviewed this quarterly report on Form 10-Q for the quarter ended September 30, 2007 of Rotech Healthcare Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation;

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 6, 2007

/s/ PHILIP L. CARTER

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**Philip L. Carter**  
President and Chief Executive Officer

**CERTIFICATION**

I, Steven P. Alsene, certify that:

1. I have reviewed this quarterly report on Form 10-Q for the quarter ended September 30, 2007 of Rotech Healthcare Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and we have:

a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation;

d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: November 6, 2007

/s/ STEVEN P. ALSENE

Steven P. Alsene  
Chief Financial Officer

