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

FORM 10-Q

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

For the quarterly period ended **June 30, 2008**

or

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

For the transition period from _____ to _____

Commission File Number **000-50940**

ROTECH HEALTHCARE INC.

(Exact Name of Registrant as Specified in Its Charter)

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)

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, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large Accelerated Filer
Non-Accelerated Filer (Do not check if smaller reporting company)

Accelerated Filer
Smaller Reporting Company

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

As of August 4, 2008, the registrant had 25,505,270 shares of common stock outstanding.

TABLE OF CONTENTS

	<u>Page No.</u>
<u>PART I—Financial Information</u>	
<u>ITEM 1—Condensed Consolidated Financial Statements (unaudited)</u>	3
<u>Condensed Consolidated Balance Sheets—June 30, 2008 and December 31, 2007</u>	3
<u>Condensed Consolidated Statements of Operations—Three and six months ended June 30, 2008 and 2007</u>	4
<u>Condensed Consolidated Statements of Cash Flows—Six months ended June 30, 2008 and 2007</u>	5
<u>Notes to Condensed Consolidated Financial Statements</u>	6
<u>ITEM 2—Management’s Discussion and Analysis of Financial Condition and Results of Operations</u>	14
<u>ITEM 3—Quantitative and Qualitative Disclosures about Market Risk</u>	34
<u>ITEM 4—Controls and Procedures</u>	34
<u>PART II—Other Information</u>	
<u>ITEM 1—Legal Proceedings</u>	35
<u>ITEM 1A—Risk Factors</u>	35
<u>ITEM 2—Unregistered Sales of Equity Securities and Use of Proceeds</u>	38
<u>ITEM 3—Defaults Upon Senior Securities</u>	38
<u>ITEM 4—Submission of Matters to a Vote of Security Holders</u>	38
<u>ITEM 5—Other Information</u>	38
<u>ITEM 6—Exhibits</u>	38
<u>SIGNATURES</u>	39

PART I—FINANCIAL INFORMATION

ITEM 1—Condensed Consolidated Financial Statements

ROTECH HEALTHCARE INC. AND SUBSIDIARIES
UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands)

	<u>June 30, 2008</u>	<u>December 31, 2007</u>
Assets		
Current assets:		
Cash and cash equivalents	\$ 44,004	\$ 55,008
Accounts receivable, net	80,186	77,081
Other accounts receivable	6,942	3,398
Income taxes receivable	338	1,926
Inventories	8,933	11,509
Prepaid expenses	3,802	4,300
Deferred tax assets, net	—	124
Total current assets	<u>144,205</u>	<u>153,346</u>
Property and equipment, net	133,311	140,356
Intangible assets (less accumulated amortization of \$8,493 at June 30, 2008 and \$7,828 at December 31, 2007)	17,652	18,316
Other goodwill	43,876	43,876
Reorganization value in excess of fair value of identifiable assets—goodwill	163,154	163,154
Restricted cash	13,343	13,330
Other assets	13,224	14,395
	<u>\$ 528,765</u>	<u>\$ 546,773</u>
Liabilities and Stockholders' Deficit		
Current liabilities:		
Accounts payable	\$ 27,431	\$ 28,183
Accrued expenses and other current liabilities	16,405	17,996
Accrued interest	9,917	10,479
Deferred revenue	10,884	10,696
Deferred tax liabilities, net	45	—
Current portion of long-term debt	488	1,287
Total current liabilities	<u>65,170</u>	<u>68,641</u>
Priority tax claim	910	1,216
Deferred tax liabilities, net	1,025	1,483
Other long-term liabilities	749	883
Long-term debt, less current portion	490,362	479,724
Series A convertible redeemable preferred stock, stated value \$20 per share, 1,000,000 shares authorized, and 245,049 shares issued and outstanding at June 30, 2008 and December 31, 2007	5,118	5,343
Stockholders' deficit:		
Common stock, par value \$.0001 per share, 50,000,000 shares authorized, 25,505,270 shares issued and outstanding at June 30, 2008 and December 31, 2008	3	3
Additional paid-in capital	505,861	505,600
Accumulated deficit	<u>(540,433)</u>	<u>(516,120)</u>
Total stockholders' deficit	<u>(34,569)</u>	<u>(10,517)</u>
	<u>\$ 528,765</u>	<u>\$ 546,773</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		Six months ended	
	June 30,		June 30,	
	2008	2007	2008	2007
Net revenues	\$ 144,406	\$ 144,323	\$ 282,719	\$ 279,691
Cost of net revenues:				
Product and supply costs	37,443	38,600	70,343	74,297
Patient service equipment depreciation	12,923	11,991	27,583	23,638
Operating costs	5,280	5,899	11,293	11,861
Total cost of net revenues	55,646	56,490	109,219	109,796
Provision for doubtful accounts	5,117	4,153	9,979	8,586
Selling, general and administrative	76,277	74,701	154,567	150,970
Depreciation and amortization	3,221	3,296	6,741	7,387
Restructuring expense	1,929	—	1,929	—
Total costs and expenses	142,190	138,640	282,435	276,739
Operating income	2,216	5,683	284	2,952
Interest expense, net	12,204	12,028	24,612	22,095
Other (income) expense, net	(4)	(2)	2	48
Loss on extinguishment of debt	—	2	—	12,171
Loss before income taxes	(9,984)	(6,345)	(24,330)	(31,362)
Federal and state income tax expense (benefit)	156	233	(242)	(3,028)
Net loss	(10,140)	(6,578)	(24,088)	(28,334)
Accrued dividends on redeemable preferred stock	113	113	225	225
Net loss attributable to common stockholders	\$ (10,253)	\$ (6,691)	\$ (24,313)	\$ (28,559)
Net loss per common share—basic	\$ (0.40)	\$ (0.26)	\$ (0.95)	\$ (1.12)
Net loss per common share—diluted	\$ (0.40)	\$ (0.26)	\$ (0.95)	\$ (1.12)
Weighted average shares outstanding—basic	25,505,270	25,505,270	25,505,270	25,488,897
Weighted average shares outstanding—diluted	25,505,270	25,505,270	25,505,270	25,488,897

See accompanying notes to unaudited condensed consolidated financial statements.

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

	Six months ended June 30,	
	2008	2007
Net loss	\$(24,088)	\$ (28,334)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Provision for doubtful accounts	9,979	8,586
Depreciation and amortization	35,620	32,555
Loss on extinguishment of debt	—	12,171
Payment-in-kind interest added to long-term borrowings	10,740	—
Deferred income taxes	(289)	(1,769)
Other reconciling adjustments	272	179
Changes in operating assets and liabilities:		
Accounts receivable	(13,084)	(10,696)
Other receivables	(3,544)	(76)
Income taxes receivable	1,588	(283)
Inventories	2,576	(938)
Prepaid expenses	497	996
Other assets	(125)	(40)
Accounts payable and accrued expenses	(1,737)	(3,825)
Other long-term liabilities	(133)	(63)
Accrued interest	(562)	4,845
Income taxes payable	—	(1,225)
Deferred revenue	188	152
Net cash provided by operating activities	<u>17,898</u>	<u>12,235</u>
Cash flows from investing activities:		
Purchases of property and equipment	(26,549)	(24,391)
Cash collateralization of letters of credit – restricted cash	(13)	(12,493)
Net cash used in investing activities	<u>(26,562)</u>	<u>(36,884)</u>
Cash flows from financing activities:		
Proceeds from short-term borrowings	—	7,000
Payments of short-term borrowings	—	(8,500)
Payments of long-term borrowings	—	(238)
Retirement of long-term borrowings	—	(94,525)
Proceeds from long-term borrowings	—	180,000
Debt issuance costs	—	(8,013)
Prepayment premium on long-term borrowings	—	(8,367)
Payments of dividends on preferred stock	(450)	(450)
Principal payments on capital leases	(1,127)	(2,989)
Changes in liabilities subject to compromise/priority tax claim	(763)	(592)
Net cash (used in) provided by financing activities	<u>(2,340)</u>	<u>63,326</u>
(Decrease) increase in cash and cash equivalents	(11,004)	38,677
Cash and cash equivalents, beginning of period	<u>55,008</u>	<u>10,265</u>
Cash and cash equivalents, end of period	<u>\$ 44,004</u>	<u>\$ 48,942</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 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, 2007. Except as otherwise discussed in Note 3, "Summary of Significant Accounting Policies", there have been no material changes to our significant accounting policies as disclosed in our consolidated financial statements and notes thereto included in our Annual Report on Form 10-K for the year ended December 31, 2007.

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 loss and comprehensive loss.

(2) Liquidity

We are highly leveraged. As of June 30, 2008, we had \$490,850 of long-term debt outstanding. Although we are highly leveraged, our current cash projections indicate that our current cash balances and cash generated from our operations will be sufficient to meet our working capital, capital expenditure and other cash needs for the next twelve months. Management believes that we have the ability to manage our cash flows in order to be able to meet our obligations as they become due during the next twelve months.

We are also required to comply with certain financial covenants under our credit agreement, including requirements regarding certain specified minimum thresholds for EBITDA (i.e., earnings before interest, taxes, depreciation and amortization). We were in compliance with such covenants as of June 30, 2008 and management believes that we will meet these covenant requirements for the next twelve months (see Note 10, *Debt*, for a discussion of the consequences of failing to comply with our covenant requirements and the events of default under our credit agreement).

(3) Summary of Significant Accounting Policies

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 relatively 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 the applicable useful life under a straight-line convention, without specific physical tracking of individual items. Each grouping of patient service equipment is assigned a useful life intended to provide proper matching of the cost of patient service equipment with the patient service revenues generated from use of the equipment, when considering the conversion of rental equipment to purchase, wear and tear, damage, loss and ultimately scrapping of patient service equipment over its life. We evaluate the useful life under the composite method on an annual basis. Effective January 1, 2008, we shortened the average useful life on patient service equipment from five years to four years. This reduction in the estimated useful life of our patient service equipment is largely attributable to shortened rent to purchase periods, as a result of provisions included in the Deficit Reduction Act of 2005 that reduced the capped rental period for certain types of home medical equipment, including continuous positive airway pressure (CPAP) devices, from 15 months to 13 months beginning January 1, 2007, and increased volume on certain types of durable medical and respiratory equipment, which result in an increased percentage of our patient service equipment converting to purchase. For the three and six months ended June 30, 2008, the decrease in useful life resulted in approximately \$1,485 and \$3,945 of additional depreciation expense, respectively. Whenever events or circumstances occur which change the estimated useful life of an asset, we account for the change prospectively. While we believe our current estimates of useful lives are reasonable, significant differences in actual experience or significant changes in assumptions may cause additional changes to future depreciation expense. On July 15, 2008, the United States Congress, following an override of a Presidential veto, enacted the Medicare Improvement for Patients and Providers Act of 2008 (H.R. 6331). H.R. 6331 repeals the transfer of title to oxygen

equipment at the end of the 36-month rental cap. We will be evaluating the impact of this policy change on the useful life assigned to the

associated equipment. Any change in useful life resulting from H.R. 6331 will be reflected prospectively beginning July 1, 2008.

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.

(4) Recent Accounting Pronouncements

In September 2006, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards No. 157, *Fair Value Measurements* (Statement 157). This statement defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosure about fair value measurements. In February 2008, the FASB issued Staff Positions FAS 157-1 and FAS 157-2 which delayed the effective date of Statement No. 157 for one year for certain non-financial assets and non-financial liabilities and removed certain leasing transactions from its scope. We adopted Statement 157 for financial assets and liabilities on January 1, 2008. It did not have any impact on our results of operations or financial position and did not result in any additional disclosures. We are in the process of evaluating the effect, if any, the adoption of FSP FAS 157-2 will have on our results of operations or financial position.

In February 2007, the FASB issued Statement No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities – Including an Amendment of FASB Statement No. 115*, which permits an entity to choose to measure certain financial instruments and other items at fair value at specified election dates. A company will report unrealized gains and losses in earnings on items for which the fair value option has been elected after adoption. The provisions of Statement No. 159 were effective as of the beginning of the 2008 calendar year. We adopted Statement 159 on January 1, 2008 resulting in no impact to our financial condition, results of operations or cash flows.

In December 2007, the FASB issued Statement No. 141(R), *Business Combinations*, which replaces Statement No. 141. Statement No. 141(R) requires an acquirer in a business combination, including business combinations achieved in stages (step acquisition), to recognize the assets acquired, liabilities assumed, and any noncontrolling interest in the acquiree at the acquisition date, measured at their fair values as of that date, with limited exceptions. It also requires the recognition of assets acquired and liabilities assumed arising from certain contractual contingencies as of the acquisition date, measured at their acquisition-date fair values. The provisions of Statement No. 141(R) are effective as of the beginning of the 2009 calendar year. The effects of the adoption of this standard in 2009 will be prospective.

(5) 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 and six months ended June 30, 2008 and 2007. 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 4,900,997 and 4,667,525 for the three months ended June 30, 2008 and 2007, respectively, 4,906,487 and 3,053,960 for the six months ended June 30, 2008 and 2007, 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 six months ended June 30, 2008 and 2007 are as follows:

	<u>Net Loss</u> <u>(Numerator)</u>	<u>Shares</u> <u>(Denominator)</u>	<u>Per Share</u> <u>Amount</u>
For the Three Months Ended June 30, 2008:			
Basic and diluted EPS:			
Net loss	\$ (10,140)		
Accrued dividends on redeemable preferred stock	113		
Net loss attributable to common stockholders	<u>\$ (10,253)</u>	<u>25,505,270</u>	<u>\$ (0.40)</u>
For the Three Months Ended June 30, 2007:			
Basic and diluted EPS:			
Net loss	\$ (6,578)		
Accrued dividends on redeemable preferred stock	113		
Net loss attributable to common stockholders	<u>\$ (6,691)</u>	<u>25,505,270</u>	<u>\$ (0.26)</u>
For the Six Months Ended June 30, 2008:			
Basic and diluted EPS:			
Net loss	\$ (24,088)		
Accrued dividends on redeemable preferred stock	225		

Net loss attributable to common stockholders	<u>\$ (24,313)</u>	<u>25,505,270</u>	<u>\$ (0.95)</u>
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	Net Loss (Numerator)	Shares (Denominator)	Per Share Amount
For the Six Months Ended June 30, 2007:			
Basic and diluted EPS:			
Net loss	\$ (28,334)		
Accrued dividends on redeemable preferred stock	225		
Net loss attributable to common stockholders	<u>\$ (28,559)</u>	<u>25,488,897</u>	<u>\$ (1.12)</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 the 2007 annual meeting of the board of directors held on June 30, 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 December 31, 2007 within "Accrued expenses and other liabilities" and were paid in January 2008. At the 2008 annual meeting of the board of directors held on June 24, 2008, 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 June 30, 2008 within "Accrued expenses and other current liabilities."

(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 will perform 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:

	June 30, 2008		December 31, 2007	
	Gross Carrying Amount	Accumulated Amortization	Gross Carrying Amount	Accumulated Amortization
Intangible assets subject to amortization:				
Customer/physician relationship	\$ 12,000	\$ 3,750	\$ 12,000	\$ 3,450
Computer software	5,000	2,083	5,000	1,917
Acquired customer lists, trade names and other	7,025	2,660	7,025	2,461
Subtotal	<u>24,025</u>	<u>8,493</u>	<u>24,025</u>	<u>7,828</u>
Intangible assets not subject to amortization:				
Trade name	1,120	—	1,120	—
Medicare licenses	1,000	—	1,000	—
Subtotal	<u>2,120</u>	<u>—</u>	<u>2,120</u>	<u>—</u>
Total intangible assets	<u>\$ 26,145</u>	<u>\$ 8,493</u>	<u>\$ 26,145</u>	<u>\$ 7,828</u>

Amortization expense for the three and six months ended June 30, 2008 was approximately \$332 and \$665, respectively. Amortization expense for the three and six months ended June 30, 2007 was approximately \$695 and \$1,044, respectively. As of June 30, 2008 and December 31, 2007, other goodwill was approximately \$43,876.

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

	Amount
2008	\$1,327
2009	1,325
2010	1,252
2011	1,181
2012	1,173

(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		Six Months Ended	
	June 30,		June 30,	
	2008	2007	2008	2007
Respiratory therapy equipment and services	\$128,497	\$127,731	\$251,031	\$247,183
Durable medical equipment	14,099	15,393	28,758	30,152
Other health care products	1,810	1,199	2,930	2,356
Net revenue	<u>\$144,406</u>	<u>\$144,323</u>	<u>\$282,719</u>	<u>\$279,691</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, both of 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, 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 Department of Veterans Affairs (VA)) and from the states under Medicaid. Revenue derived from Medicare, Medicaid and other federally funded programs represented 64.9% and 65.9% of our patient revenue for the three months ended June 30, 2008 and 2007, respectively, and 64.8% and 66.5% for the six months ended June 30, 2008 and 2007, 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 lawsuit that 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. In January 2008, the Assistant United States Attorney handling the investigation advised the Company that the U.S. Attorney's Office was declining to pursue any of the issues being investigated with the exception of issues relating to our provision of certain supplies to the Maine Medicaid program, which remain under investigation. 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 (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 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 "OIG"). 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 produced the requested documents in January 2007 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.

On May 16, 2008, we entered into a Corporate Integrity Agreement (the "2008 CIA") with the OIG in connection with the resolution of a previously reported qui tam complaint brought by one of our former employees. The action was filed on April 6, 2004 and alleged violations of the False Claims Act between February 22, 1996 and April 30, 2003. In settling the litigation, we did not admit wrongdoing but paid \$2.0 million plus interest to the United States Treasury Department and \$1.4 million to the former employee for expenses and attorney's fees and costs. The settlement amount was paid on May 19, 2008; the associated expense was previously recorded as legal settlement in the statement of operations for the three months and year ended December 31, 2007.

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 2008 CIA is intended to promote continued compliance by the Company with the statutes, regulations, and written directives of Medicare, Medicaid, and all other federal health care programs. The 2008 CIA provides that we will maintain and enhance our existing compliance program. We are also subject to notification and reporting requirements with respect to specified events under the 2008 CIA. The 2008 CIA has a term of three years.

In addition, our Predecessor and the OIG entered into a CIA (the "2002 CIA") 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 2002 CIA. The term of the 2002 CIA 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 2002 CIA, we

may be subject to substantial penalties, including stipulated cash penalties ranging from \$1.00 per day to \$2.50 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:

	June 30, 2008	December 31, 2007
Capital lease obligations with interest implied at fixed rates between 6.3% and 8.3%, due in equal monthly installments with terms expiring from June 2010 through December 2010, secured by equipment	\$ 418	\$ 504
Capital lease obligations with interest implied at a fixed rate of 10.8%, due in three installments payable in 2008 and 2009, secured by equipment	290	1,105
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	203,142	192,402
9 1/2% senior subordinated notes, due April 1, 2012, interest payable semi-annually on April 1 and October 1	287,000	287,000
Sub-total	490,850	481,011
Less current portion	488	1,287
Total long-term debt	<u>\$490,362</u>	<u>\$ 479,724</u>

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 based on the Base Rate, as defined in such credit agreement, plus 5% or the Eurodollar Rate plus 6% (9.0% as of June 30, 2008). 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 shall be 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 six months ended June 30, 2008. Accordingly, during the six months ended June 30, 2008, a total of \$10,740 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 \$203,142 as of June 30, 2008. As of June 30, 2008, we have \$3,073 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 in March 2007. 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 six months ended June 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 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 \$12,198 as of June 30, 2008, which are cash collateralized at 105% of their face amount. The cash collateral for these outstanding letters of credit is included in the \$13,343 of restricted cash in our accompanying consolidated balance sheet as of June 30, 2008.

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 expense of \$156 for the three months ended June 30, 2008 and a net tax benefit of \$242 for the six months ended June 30, 2008. The year to date tax benefit is primarily the result of the favorable audit experiences with states resulting in a \$289 reduction in our liabilities recorded under FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes* (FIN 48) which is offset by current state tax expense of \$47. We have provided a full valuation allowance against our remaining net deferred tax assets as of June 30, 2008 because management's judgment is that it is more likely than not that the net deferred tax assets resulting from the net loss for the six months ended June 30, 2008 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.

At June 30, 2008, we had available federal net operating loss (NOL) carryforwards of approximately \$135,170. 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. 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.

Under FIN 48, we recorded a liability of \$1,070 and \$1,359 for unrecognized tax benefits related to various federal and state income tax matters as of June 30, 2008 and December 31, 2007, respectively. If recognized, all of these amounts 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 based on the current valuation of the deferred tax assets. We expect that the amounts of unrecognized tax benefits will decrease within the next 12 months because of expiring statutes of limitations in a number of states.

We are currently open to audit under the statute of limitations by the Internal Revenue Service for all years ending December 31, 2002 to present. However, we are only open to additional tax assessments under the Internal Revenue Code statute of limitations for the years ending December 31, 2004 to present. Our state income tax returns are open to audit and additional tax assessments under the various state statutes of limitations for the years ending December 31, 2002 through 2007.

There is \$183 and \$209 of accrued interest related to uncertain tax positions as of June 30, 2008 and December 31, 2007, respectively. No penalties have been accrued. We account for interest and penalties related to uncertain tax positions as part of our provision for federal and state income taxes.

(12) Restructuring Expense

In response to the significant reductions in Medicare reimbursement for nebulizer medications, we initiated and have substantially completed a restructuring of our clinical programs and pharmacy operations during the three months ended June 30, 2008. We believe that the changes associated with this restructuring will allow us to continue offering mail-order nebulizer medications to our patients absent any further significant reductions in Medicare reimbursement for these products. In conjunction with this restructuring, we have recorded \$1,929 of restructuring expense for the three and six months ended June 30, 2008, which primarily consists of severance amounts payable to former employees. Unpaid severance payments of \$1,196 are included in our accompanying consolidated balance sheet as of June 30, 2008 within "Accrued expenses and other current liabilities."

Balance as of December 31, 2007	\$	—
Charges		1,929
Payments		<u>(733)</u>
Balance as of June 30, 2008	\$	<u>1,196</u>

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

	For the six months ended June 30,	
	2008	2007
Cash payments (receipts) for:		
Interest	\$14,052	\$16,129
Income taxes	\$(1,541)	\$ 249
Non-cash investing activities:		
Purchases of property and equipment included in accounts payable	\$ 2,811	\$ 3,755
Non-cash financing activities:		
Payment-in-kind interest added to principal	\$10,740	\$ 1,755
Assets acquired under capital lease	\$ 228	\$ 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, 2007 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.

Introduction

Background

We are one of the largest providers of 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. We provide our equipment and services principally to older patients with breathing disorders, such as chronic obstructive pulmonary diseases (COPD), which include chronic bronchitis, emphysema, obstructive sleep apnea and other cardiopulmonary disorders.

Our revenues are principally derived from respiratory equipment rental and related services, which accounted for 89.0% and 88.5% of net revenues for the three months ended June 30, 2008 and 2007, respectively and 88.8% and 88.4% of net revenues for the six months ended June 30, 2008 and 2007, 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, which accounted for 9.8% and 10.7% of net revenues for the three months ended June 30, 2008 and 2007, respectively and 10.2% and 10.8% of net revenues for the six months ended June 30, 2008 and 2007, respectively. Revenues from rental and sale of durable medical equipment include hospital beds, wheelchairs, walkers, patient aids and ancillary supplies. We derive our revenues principally from reimbursement by third party payors, including Medicare, Medicaid, the Department of Veterans Affairs and private insurers.

We are focused on specific initiatives to continue the growth in patient and product counts experienced over the past three years. We continue to further develop our sales and operational training programs, and have introduced new incentive programs that we believe will better equip and motivate our sales force, and ultimately drive additional growth. In addition, we have recently completed a migration of our proprietary billing system onto a new platform, which we believe will allow us to reduce future labor costs, shorten our billing and collection cycle, and reduce revenue adjustments. In response to the significant reductions in Medicare reimbursement for nebulizer medications, we have substantially completed a restructuring of our clinical programs and pharmacy operations. We believe that the changes associated with this restructuring will allow us to continue offering mail-order nebulizer medications to our patients absent any further significant reductions in Medicare reimbursement for these products. We also continue to actively monitor and manage our cash position and capital expenditures on a daily basis.

Overview

We face significant financial and Medicare reimbursement related challenges that continue to negatively affect our financial position. We anticipate that we will continue to face such challenges in the near and long-term future. Most of these difficulties result from our highly leveraged capital structure, while others are the result of significant Medicare reimbursement reductions applicable to our industry, as well as current conditions in the capital markets. In particular:

- Although we refinanced our long-term debt in March 2007, interest payments due under our senior subordinated notes, accruing interest under our senior secured debt, capital expenditure requirements, and a difficult credit market may inhibit our ability to refinance our debt and could adversely affect our long-term liquidity.
- We expect that the 36-month rental cap on oxygen equipment provided to Medicare beneficiaries, mandated as part of the Deficit Reduction Act of 2005, will materially adversely affect our revenues, profit margins, profitability, operating cash flows and results of operations commencing in 2009.
- Recent and potential future changes in Medicare policies, including freezes and reductions in reimbursement rates for home medical equipment and dispensing fee reductions, proposed competitive bidding requirements, new clinical conditions for reimbursements, accreditation requirements and quality standards, could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.
- We continue to explore various strategic transactions and, if our efforts are not successful, we may be required to consider additional alternatives in restructuring our business and our capital structure, including filing for bankruptcy protection, which likely would result in our creditors receiving an amount that is less than the full amount of the debt owed them and the elimination of all value of our outstanding common stock.

Strategic Initiatives

As a result of our highly leveraged position and the regulatory environment in which we operate, we continue to explore various strategic transactions, such as an acquisition, debt exchange, equity offering, or a combination of any such transactions. At June 30, 2008, we had approximately \$490.9 million of long-term debt outstanding. One of the greatest risks relating to our high leverage is the possibility that a substantial down-turn in operating cash flows, including as a result of adverse regulatory changes, could jeopardize our ability to service our debt payment obligations as discussed below. We continue to face the risk of future material adverse regulatory changes, similar to those experienced over the past several years. Beginning in 2009, we expect that CMS' final rule to implement the DRA's 36-month rental cap on oxygen equipment with regard to oxygen reimbursement as released in November 2006 will have a material adverse impact on our financial position. In addition, recent legislation includes a 9.5% reduction in reimbursement for oxygen and certain other durable medical equipment, effective January 1, 2009. This reimbursement reduction will also have a material adverse impact on our financial position. The risks and uncertainties related to the DRA's 36-month rental cap, as well as the impact of recent reimbursement changes, are discussed in more detail below under the heading "Medicare Laws and Regulations." 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.

NASDAQ Delisting

As previously reported, on June 10, 2008, following a hearing conducted on June 5, 2008 before a NASDAQ Hearings Panel and additional discussions with the Staff of the NASDAQ, we received a letter from the NASDAQ Office of General Counsel indicating that trading of our shares would be suspended effective at the open of business on Thursday, June 12, 2008 and subsequently delisted. Following the delisting of our securities, we are now quoted on the OTC Bulletin Board, a regulated quotation service that displays real-time quotes, last sale prices and volume information in over-the-counter securities.

Reimbursement by Third Party Payors

We derive substantially all of our revenues from reimbursement by third party payors, including Medicare, Medicaid, the Department of Veteran Affairs (VA) and private insurers. Revenue derived from Medicare, Medicaid and other federally funded programs represented 64.9% and 65.9% of our patient revenue for the three months ended June 30, 2008 and 2007, respectively and 64.8% and 66.5% of our patient revenue for the six months ended June 30, 2008 and 2007, respectively. Our business has been, and may continue to be, significantly impacted by changes mandated by Medicare legislation.

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 (BBA) granted authority to the Secretary of the Department of Health and Human Services (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 regulation 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 the Centers for Medicare and Medicaid Services (CMS), the agency within the DHHS responsible for administering the Medicare program, 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. The implementation of the inherent reasonableness procedure itself does not trigger payment adjustments for any items or services and to date, no payment adjustments have occurred or been proposed under this inherent reasonableness procedure.

In addition to its inherent reasonableness authority, CMS has the discretion to reduce the reimbursement for home medical equipment (HME) to an amount based on the payment amount for the least costly alternative (LCA) treatment that meets the Medicare beneficiary's medical needs. 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. 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.

Recent legislation, each of which has been signed into law, including the Medicare, Medicaid and State Children's Health Insurance Program Extension Act of 2007 ("SCHIP Extension Act"), the Deficit Reduction Act of 2005 ("DRA") and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), contain provisions that negatively impact reimbursement for the primary HME products that we provide. The SCHIP Extension Act reduced Medicare reimbursement amounts for covered Medicare Part B drugs, including inhalation drugs that we provide, beginning April 1, 2008. The DRA contains provisions that will negatively impact reimbursement for oxygen equipment beginning in 2009 and negatively impacted reimbursement for HME items subject to capped rental payments beginning January 1, 2007. The MMA significantly reduced reimbursement for inhalation drug

therapies beginning in 2005, reduced payment amounts for five categories of HME, including oxygen, beginning in 2005, froze payment amounts for other covered HME items through 2007, established a competitive bidding program for HME and implemented quality standards and accreditation requirements for HME suppliers. The SCHIP Extension Act, DRA and MMA provisions, and the recently enacted Medicare Improvement for Patients and Providers Act of 2008 (described below), when fully implemented, could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations. We cannot predict the impact that any federal legislation enacted in the future will have on our revenues, profit margins, profitability, operating cash flows and results of operations.

Changes in the law or new interpretations of existing laws could have a dramatic effect on permissible activities, the relative costs associated with doing business and the amount of reimbursement by government and other third-party payors. Reimbursement from Medicare and other government programs is subject to federal and state statutory and regulatory requirements, administrative rulings, interpretations of policy, implementation of reimbursement procedures, renewal of Veterans Administration contracts, retroactive payment adjustments and governmental funding restrictions. Our levels of revenue and profitability, like those of other health care companies, are affected by the continuing efforts of government payors to contain or reduce the costs of health care by lowering reimbursement rates.

(1) Competitive Bidding Program for HME. On April 2, 2007, CMS issued 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 the competitive bidding program, suppliers compete for the right to provide items to beneficiaries in a defined region. CMS selects contract suppliers that agree to receive as payment the “single payment amount” calculated by CMS after bids are submitted. Round one of the competitive bidding program began on July 1, 2008 in ten high-population MSAs. As a winning bidder in nine of the ten competitive bidding areas, we signed contracts with CMS to become a contracted supplier for the round one contract period of July 1, 2008 through June 30, 2011. The competitive bidding program was scheduled to expand to 70 additional MSAs for a total of 80 MSAs in 2009 and additional areas thereafter.

However, on July 15, 2008, the United States Congress, following an override of a Presidential veto, enacted the Medicare Improvement for Patients and Providers Act of 2008 (H.R. 6331). H.R. 6331 retroactively delays the implementation of competitive bidding for eighteen months, and terminates all existing contracts previously awarded. H.R. 6331 includes a 9.5% nationwide reduction in reimbursement effective January 1, 2009 for the product categories included in competitive bidding, as a budget-neutrality offset for the eighteen month delay. Based on current product volumes, management estimates that H.R. 6331 will negatively impact our annual revenue and net income by approximately \$17.0 million, compared to our original estimated negative annual impact of approximately \$4.0 million as a result of the reduced reimbursement in the first round of competitive bidding. As a winning supplier, we expected to experience increased product volumes within the CBAs included in the first round of competitive bidding, which could have offset some portion of the negative impact of the reduced pricing.

(2) Certain Clinical Conditions, Accreditation Requirements and Quality Standards. The MMA required establishment and implementation of new clinical conditions of coverage for HME products and quality standards for HME suppliers. 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. CMS published its quality standards and criteria for accrediting organizations for HME suppliers in 2006. 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 are applied by independent accreditation organizations, 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 regulation governing competitive bidding, when implemented, requires that all suppliers meet these new quality standards and also meet additional financial standards.

Currently, all of our operating centers are accredited by the Joint Commission (formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations). The Joint Commission is a CMS recognized accrediting organization. Round one competitive bid suppliers were required to become accredited by October 31, 2007 to be selected as a contract supplier. However, because the enactment of H.R. 6331 delays the competitive bidding program, all suppliers will now be required to be accredited by September 30, 2009.

On January 25, 2008, CMS published a proposed rule to clarify, expand and add to the existing enrollment requirements that Durable Medical Equipment and Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers must satisfy to establish and maintain billing privileges in the Medicare program. Included in the proposed rule are revised or clarified requirements regarding contracting with an individual or entity to provide licensed services, record retention, clarification of the term “appropriate site” as set forth in the regulation (which may be expanded to include a minimum square footage requirement), use of cell phones and beepers/pagers as a method of receiving calls from the public or beneficiaries, comprehensive liability insurance, patient solicitation, maintenance of ordering and referring documentation, sharing of a practice location with another Medicare provider, and minimum operating hours. At this time, we cannot predict the impact that this proposed rule, if implemented, would have on our business.

(3) Reduction in Payments for HME and Inhalation Drugs. The MMA changes also included a reduction in reimbursement rates beginning in January 2005 for oxygen equipment and certain other items of home medical equipment (including wheelchairs, nebulizers, hospital beds and air mattresses) 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 (FEHBP) as determined by the Office of the Inspector General of the DHHS. The FEHBP adjusted payments are to remain “frozen” through 2008.

The MMA also revised the payment methodology for certain drugs, including inhalation drugs dispensed through nebulizers. Historically, prescription drug coverage under Medicare has been limited to drugs furnished incident to a physician’s services and certain self-administered drugs, including inhalation drug therapies. Prior to MMA, Medicare reimbursement for covered drugs, including the inhalation drugs that we provide, was limited to 95 percent of the published average wholesale price (AWP) for the drug. MMA established new payment limits and procedures for drugs reimbursed under Medicare Part B. Beginning in 2005, inhalation drugs furnished to Medicare beneficiaries are reimbursed at 106 percent of the volume-weighted average selling price (ASP) of the drug, as determined from data provided each quarter by drug manufacturers under a specific formula described in MMA. Implementation of the ASP-based reimbursement formula resulted in a significant reduction in payment rates for inhalation drugs. Given the overall reduction in payment for inhalation drugs dispensed through nebulizers, CMS established a dispensing fee for inhalation drugs shipped to a beneficiary beginning in 2005. The dispensing fee is \$57 for the first 30-day period in which a Medicare beneficiary uses inhalation drugs and \$33 for each subsequent 30-day period. The dispensing fee for a 90-day supply of inhalation drugs is \$66. The dispensing fee has remained unchanged since 2006. Future changes from quarterly updates to ASP pricing, as well as any 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, 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 discontinued all compounding operations.

Effective July 1, 2007, CMS also revised its payment methodology billing codes for non-compounded albuterol and levalbuterol. Payment rates for these products were based on a weighted average of the average sales prices (ASPs) for both products. The 2007 Medicare payment rates for concentrated and single dose albuterol and levalbuterol were 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

On December 29, 2007, the President of the United States signed into law the Medicare, Medicaid, and State Children’s Health Insurance Program Extension Act of 2007 (“SCHIP Extension Act”). The SCHIP Extension Act incorporated a special rule, effective April 1, 2008, such that albuterol payment rates were not combined with those of levalbuterol. This resulted in a decrease in the payment amounts for albuterol. The payment rates for the first three quarters of 2008 for concentrated and single dose albuterol and levalbuterol are as follows:

Medicare payment rates effective:	Concentrated Albuterol (1mg)	Concentrated Levalbuterol (.5mg)	Single Dose Albuterol	Single Dose Levalbuterol
1/1/2008 – 3/31/2008	\$ 0.153	\$ 0.153	\$ 1.105	\$ 1.105
4/1/2008 – 6/30/2008	\$ 0.070	\$ 0.135	\$ 0.110	\$ 0.698
7/1/2008 – 9/30/2008	\$ 0.082	\$ 0.120	\$ 0.100	\$ 0.575

We estimate that the reduction in the reimbursement rate for single dose albuterol will reduce our revenue by approximately \$12.7 million on an annual basis. In addition, the SCHIP Extension Act requires CMS to apply an alternative volume weighting computation to its calculation of ASP-based payment amounts. When implemented, the new methodology is expected to reduce the Medicare payment amounts. The Congressional Budget Office (CBO) estimates that the provisions of the SCHIP Extension Act affecting Medicare Part B drug reimbursement will result in reductions in aggregate Medicare outlays for such drugs of \$1.0 billion over five years and \$2.6 billion over 10 years.

Furthermore, because the ASP amounts vary from quarter to quarter, changes in market forces influence the Medicare payment rate. In late 2006, the US Food and Drug Administration approved a first-time generic formulation for DuoNeb. The introduction of this generic product into the market has contributed to the reduction of the ASP for DuoNeb from \$1.079 in the fourth quarter of 2007 to \$0.805 in the first quarter of 2008, \$0.830 in the second quarter 2008, and \$0.581 in the third quarter 2008. We estimate that this reduction in ASP for DuoNeb will reduce our revenue by approximately \$2.7 million per quarter as compared to the fourth quarter of 2007. The impact of this reduction to our profit margins, profitability, operating cash flows and results of operations is partially mitigated through the dispensing of generic DuoNeb.

In addition to these decreases in payment amounts for albuterol, levalbuterol and DuoNeb, on April 10, 2008, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) issued a local coverage determination that would cause further reductions in Medicare payments for these products. Specifically, effective for claims with dates of service on or after July 1, 2008, claims for non-compounded levalbuterol and DuoNeb were to be paid based on the allowance for “the least costly medically appropriate alternative.” For levalbuterol, payment would be based on non-compounded albuterol. Claims for DuoNeb would be based on the individual non-compounded unit dose vials of albuterol and ipratropium. However, on June 12, 2008, CMS instructed the DME MACs to withdraw the least costly alternative policy for levalbuterol until receipt of further guidance from CMS. In addition, on June 20, 2008, CMS delayed implementation of least costly alternative policies with respect to DuoNeb until November 1, 2008. We cannot predict the ultimate resolution of these least costly alternative policies; however, based upon current volumes, we estimate that, if implemented, the changes in reimbursement for levalbuterol and DuoNeb would further reduce our revenue by approximately \$4.7 million per quarter.

Deficit Reduction Act

The DRA which was signed into law on February 8, 2006, has made certain changes to the way Medicare Part B pays for our HME products, including capped rental items and oxygen equipment. 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. In addition to the changes in the duration of the rental period for capped rental items and oxygen equipment, the DRA permits payments for servicing and maintenance of the products after ownership transfers to the beneficiary.

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 clarified the DRA’s 36-month rental cap on oxygen equipment. 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 described below. With the passage of H.R. 6331 on July 15, 2008, transfer of title to oxygen equipment at the end of the 36-month rental cap was repealed. Effective January 1, 2009, after the 36th continuous month during which payment is made for the oxygen equipment, the equipment is to continue to be furnished during any period of medical need for the remainder of the reasonable useful lifetime of the equipment. After the 36-month rental cap, payment is made for oxygen and for reasonable and necessary maintenance and servicing (for parts and labor not covered by the supplier’s or manufacturer’s warranty).

- **Payment for Rental Period.** For stationary oxygen equipment, the 2008 payment amount is \$199.28, an increase of \$0.88 from the 2007 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 36-Month Rental Cap.** 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 stationary and portable systems after the 36 month rental cap. 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 uses 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 acknowledged certain other payments after the 36-month rental cap, 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 the 36-month rental cap. While the changes in rental periods and payment amounts for capped rental items and oxygen equipment did not 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.

Federal and State Regulatory Requirements

Under the Federal Food Drug and Cosmetic Act (FFDCA), the Food and Drug Administration (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 with regulatory authorities in the states in which we do business, 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 federal and state 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.

We discontinued our pharmacy compounding operations in April 2007, after receiving a warning letter from the FDA in August 2005 and engaging in subsequent communications with the Agency regarding our compounding activities. We worked in collaboration with the physicians of our patients who were receiving compounded medications to obtain new prescriptions for commercially available drug products, where clinically appropriate. The FDA conducted a follow-up inspection of our Pulmo-Dose pharmacy distribution center 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.

Professional Licensure

Nurses, pharmacists and other health care professionals employed by us are required to be individually licensed or certified under applicable state law. We take steps to assure that our employees possess all necessary licenses and certifications, and we believe that our employees comply in all material respects with applicable licensure or certification laws.

Claims Audits

DME MACs and DME Program Safeguard Contractors are private organizations that contract to serve as the government's agents for processing of claims and for conducting periodic pre-payment and post-payment reviews and other audits of claims for home medical equipment and inhalation drugs dispensed through a nebulizer under Part B of the Medicare program. Medicaid agencies also conduct similar reviews and audits of claims submitted. Medicare and Medicaid agents are under increasing pressure to scrutinize health care claims more closely. In addition, the industry in which we operate is generally characterized by long collection cycles for accounts receivable due to complex and time-consuming documentation and claims processing and other requirements for obtaining reimbursement from private and governmental third-party payors. Such protracted collection cycles can lead to delays in obtaining reimbursement. Furthermore, reviews and/or similar audits or investigations of our claims and related documentation could result in denials of claims for payment submitted by us. The government could demand significant refunds or recoupments of amounts

paid by the government for claims which, upon subsequent investigation, are determined by the government to be inadequately supported by the required documentation.

The Anti-Kickback Statute

As a provider of services under the Medicare and Medicaid programs, we are subject to the Medicare and Medicaid fraud and abuse laws (sometimes referred to as the “Anti-Kickback Statute”). At the federal level, the Anti-Kickback Statute prohibits any person from knowingly and willfully soliciting, receiving, offering or providing any remuneration, including a bribe, kickback or rebate, directly or indirectly, in return for or to induce the referral of patients, or the furnishing, recommending, or arranging for products or services covered by federal health care programs. Federal health care programs have been defined to include plans and programs that provide health benefits funded by the federal government, including Medicare and Medicaid, among others. Violations of the Anti-Kickback Statute may result in civil and criminal penalties including fines of up to \$25,000 per violation, civil monetary penalties of up to \$50,000 per violation, assessments of up to three times the amount of the prohibited remuneration, imprisonment, and exclusion from participation in the federal health care programs. The Office of the Inspector General of the DHHS has published regulations that identify a limited number of specific business practices that fall within safe harbors which are deemed not to violate the Anti-Kickback Statute. Although we attempt to structure our business relationships to meet safe harbor requirements, it is possible that not all of our business relationships comply with the elements of one or more safe harbors. Conformity with the safe harbors is not mandatory and failure to meet all of the requirements of an applicable safe harbor does not make conduct per se illegal. The Office of Inspector General is authorized to issue advisory opinions regarding the interpretation and applicability of the federal Anti-Kickback Statute, including whether an activity constitutes grounds for the imposition of civil or criminal sanctions. However, we have not sought such an opinion.

In addition, a number of states in which we operate have anti-fraud and anti-kickback laws similar to the Anti-Kickback Statute that prohibit certain direct or indirect payments if such arrangements are designed to induce or encourage the referral of patients or the furnishing of goods or services. Some states’ anti-fraud and anti-kickback laws apply only to goods and services covered by Medicaid. Other states’ anti-fraud and anti-kickback laws apply to all health care goods and services, regardless of whether the source of payment is governmental or private. Further, many states prohibit revenue sharing or fee splitting arrangements between physicians and other third parties. Possible sanctions for violation of these restrictions include exclusion from state-funded health care programs, loss of licensure and civil and criminal penalties. Such statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies.

Physician Self-Referrals

Certain provisions of the Omnibus Budget Reconciliation Act of 1993, commonly known as “Stark II,” prohibit us, subject to certain exceptions, from submitting claims to the Medicare and Medicaid programs for “designated health services” if we have a financial relationship with the physician making the referral for such services or with a member of such physician’s immediate family. The term “designated health services” includes several services commonly performed or supplied by us, including durable medical equipment, home health services and parenteral and enteral nutrition. In addition, “financial relationship” is broadly defined to include any ownership or investment interest or compensation arrangement involving remuneration between us and the physician at issue. Violations of Stark II may result in loss of Medicare and Medicaid reimbursement, civil penalties and exclusion from participation in the Medicare and Medicaid programs. A person who engages in a scheme to circumvent the Stark Law’s referral prohibition may be subject to penalties as well. On September 5, 2007, CMS published the third phase of its final rulemaking “Stark III.” The amendments reflected in Stark III were originally intended to go into effect on December 4, 2007; however, the Federal Register announced that publication of Stark III has been extended until March 26, 2008, and Phase II will remain in effect through that date.

On January 4, 2001, CMS issued the first of three phases of final regulations (“Phase I”) to clarify the meaning and application of Stark II. On March 26, 2004, CMS released the second phase of the final regulations (“Phase II”). On September 5, 2007, CMS released the third phase of the final regulations (“Phase III”). The Phase I and Phase II final regulations address the primary substantive aspects of the prohibition and various exceptions. The Phase I regulations defined previously undefined key terms, clarified prior definitions, and created exceptions for certain “indirect compensation arrangements,” “fair market value” transactions, arrangements involving non-monetary compensation up to \$300, and risk-sharing arrangements, among others. For certain indirect compensation relationships, the regulations permit providers to bill for items provided in connection with an otherwise prohibited referral, if the provider does not know, and does not act in reckless disregard or deliberate ignorance of, the identity of the referring physician. Phase I of the final regulations became effective on January 4, 2002, except with respect to enforcement of the prohibition’s application to certain percentage physician compensation arrangements, which effectiveness was delayed several times by CMS. In the Phase II final regulations, which became effective on July 26, 2004, CMS addressed remaining Stark exceptions not addressed in the Phase I regulation—primarily related to compensation arrangements, but also addressed certain exceptions related to ownership and investment interests, reporting requirements and sanctions. CMS also finalized its approach to percentage compensation arrangements, permitting them in certain circumstances. In the Phase III final regulations, which became effective on December 4, 2007, CMS clarified certain Stark exceptions and addressed questions, concerns and ambiguities arising from Phases I and II of the Stark regulations.

In addition, a number of the states in which we operate have similar or broader prohibitions on physician self-referrals. Finally, enforcement activity and resulting case law developments have increased the legal risks of physician compensation arrangements that do not satisfy the terms of an exception to Stark II, especially in the area of joint venture arrangements with physicians.

False Claims

We are subject to state and federal laws that govern the submission of claims for reimbursement. The federal False Claims Act imposes civil liability on individuals or entities that submit false or fraudulent claims for payment to the government. Violations of the False Claims Act may result in treble damages, civil monetary penalties for each false claim submitted and exclusion from the Medicare and Medicaid programs. In addition, we could be subject to criminal penalties under a variety of federal statutes to the extent that we knowingly violate legal requirements under federal health programs or otherwise present false or fraudulent claims or documentation to the government.

The False Claims Act also allows a private individual to bring a qui tam suit on behalf of the government against a health care provider for violations of the False Claims Act. A qui tam suit may be brought by, with only a few exceptions, any private citizen who has material information of a false claim that has not yet been disclosed previously. Even if disclosed, the original source of the information leading to the public disclosure may still pursue such a suit. Although a corporate insider is often the plaintiff in such actions, an increasing number of outsiders are pursuing such suits.

In a qui tam suit, the private plaintiff is responsible for initiating a lawsuit that may eventually lead to the government recovering money of which it was defrauded. After the private plaintiff has initiated the lawsuit, the government must decide whether to intervene in the lawsuit and become the primary prosecutor. In the event the government declines to join the lawsuit, the private plaintiff may choose to pursue the case alone, in which case the private plaintiff's counsel will have primary control over the prosecution (although the government must be kept apprised of the progress of the lawsuit and will still receive at least 70% of any recovered amounts). In return for bringing the suit on the government's behalf, the statute provides that the private plaintiff is to receive up to 30% of the recovered amount from the litigation proceeds if the litigation is successful. The number of qui tam suits brought against health care providers has increased dramatically. In addition, at least five states— California, Illinois, Florida, Tennessee and Texas—have enacted laws modeled after the False Claims Act that allow those states to recover money which was fraudulently obtained by a health care provider from the state (e.g., Medicaid funds provided by the state).

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 ("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 (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 HIPAA 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.

CMS also published a final rule under HIPAA 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 were required to comply with this standard by May 23, 2007. We have evaluated this rule to determine the effects of the rule on our business, and 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.

Compliance Program

We have several voluntary programs to monitor compliance with federal and state laws and regulations applicable to health care entities which are designed to minimize the likelihood that we would engage in conduct or enter into contracts in violation of the fraud and abuse laws. While we believe that our compliance program meets the relevant guidance provided by the Office of Inspector General of the DHHS, we cannot provide any assurance that current or future administrative or judicial interpretations of existing laws or legislative enactment of new laws will not have a material adverse effect on our business.

Health Care Reform Legislation

Economic, political and regulatory influences are subjecting the health care industry in the United States to fundamental change. Health care reform proposals have been formulated by the legislative and administrative branches of the federal government. In addition, some of the states in which we operate periodically consider various health care reform proposals. We anticipate that federal and state government bodies will continue to review and assess alternative health care delivery systems and payment methodologies and public debate of these issues will continue in the future. Due to uncertainties regarding the ultimate features of reform initiatives and their enactment and implementation, we cannot predict, which, if any, of such reform proposals will be adopted or when they may be adopted or that any such reforms will not have a material adverse effect on our business, revenues, profit margins, profitability, operating cash flows and results of operations.

Health care is an area of extensive and dynamic regulatory change. Changes in the law or new interpretations of existing laws can have a dramatic effect on permissible activities, the relative costs associated with doing business and the amount of reimbursement by government and other third-party payors.

Corporate Integrity Agreement

On May 16, 2008, we entered into a Corporate Integrity Agreement (the “2008 CIA”) with the OIG in connection with the resolution of a previously reported qui tam complaint brought by one of our former employees. The action was filed on April 6, 2004 and alleged violations of the False Claims Act between February 22, 1996 and April 30, 2003. In settling the litigation, we did not admit wrongdoing but paid \$2.0 million plus interest to the United States Treasury Department and \$1.4 million to the former employee for expenses and attorney’s fees and costs. The settlement amount was paid on May 19, 2008; the associated expense was previously recorded as legal settlement in the statement of operations for the three months and year ended December 31, 2007.

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 2008 CIA is intended to promote continued compliance by the Company with the statutes, regulations, and written directives of Medicare, Medicaid, and all other federal health care programs. The 2008 CIA provides that we will maintain and enhance our existing compliance program. We are also subject to notification and reporting requirements with respect to specified events under the 2008 CIA. The 2008 CIA has a term of three years.

In addition, our Predecessor, Rotech Medical Corporation, and the OIG entered into a CIA (the “2002 CIA”) 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 2002 CIA. The term of the 2002 CIA 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 2002 CIA, 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.

Suppliers

We purchase our patient service equipment and supplies from a variety of independent suppliers, with whom we generally have long-standing relationships. Although we are not dependent upon any one supplier, we do currently purchase approximately 65% of our patient service equipment and supplies from five suppliers. We typically focus on one or two suppliers in each product category in an effort to maximize delivery efficiency and gross margins. We do believe that most of our supplies can be provided by multiple suppliers; however, loss or disruption of a supplier relationship could cause delays in service delivery which could adversely affect our revenues, profit margins, profitability, operating cash flows and result of operations.

Sales

We believe that the sales and marketing skills of our employees are instrumental to the success of our business. We provide marketing, training, product and service information to all of our technical personnel through our intranet and through seminars conducted on a company-wide basis so that they can communicate effectively with physicians about our equipment and services. We emphasize the cross-marketing of all our equipment and services to physicians with which we have already developed professional relationships.

Quality Control

We are committed to providing consistently high quality equipment and services. Our quality control procedures and training programs are designed to promote greater responsiveness and sensitivity to individual patient needs and to provide a high level of quality assurance and convenience to the patient and the referring physician. Licensed respiratory therapists and registered nurses provide professional health care support. The Joint Commission is a nationally recognized organization which develops standards for various health care industry segments and monitors compliance with those standards through voluntary surveys of participating providers. Accreditation by the Joint Commission entails a lengthy review process that is conducted at least every three years. We believe that our accreditation by the Joint Commission is indicative of our commitment to providing consistently high quality equipment and services. Currently, all of our operating centers are accredited by the Joint Commission.

Competition

The home medical equipment market is highly competitive and divided among a large number of providers, some of which are national providers, but most of which are either regional or local providers. Our largest national home medical equipment provider competitors are Apria Healthcare Group, Inc., Lincare Holdings, Inc., American Home Patient, Inc., Praxair, Inc. and Air Products and Chemicals, Inc. The rest of the market consists of several medium-size competitors, as well as numerous small (under \$5 million in revenues) local operations. We also face competition from other types of health care providers, including hospitals, home health agencies and health maintenance organizations. We believe that the most important competitive factors in the regional and local markets are:

- reputation with referral sources, including local physicians and hospital-based professionals;
- service quality and responsiveness;
- overall ease of doing business;
- quality of patient care, including clinical expertise;
- range of home medical equipment and services; and
- being a low cost provider.

We believe that it is important to be able to offer a broad range of complementary equipment and services to provide patients access through a single source. We believe that we compete effectively with respect to all of the above factors and that we have an established record as a quality provider of a range of complementary home medical equipment and services.

Insurance

Our business is subject to general and professional liability, products liability, employment practices liability, workers' compensation, automobile liability, personal injury and other liability claims that are generally covered by insurance. We have insurance policies that contain various customary levels of deductibles and self insured retentions and provide us with protection against claims alleging bodily injury or property damage arising out of our operations. Furthermore, the losses that are insured through commercial insurance are subject to the credit risk of those insurance companies. While we believe our commercial insurance providers are currently credit worthy, there can be no assurance that such insurance companies will remain so in the future. These insurance policies are subject to annual renewal. We believe that our insurance coverage is appropriate based upon historical claims and the nature and risks of our business.

Results of Operations

The following table shows our results of operations for the three and six months ended June 30, 2008 and 2007 (in thousands).

	Three months ended		Six months ended	
	June 30,		June 30,	
	2008	2007	2008	2007
Net revenues	\$144,406	\$144,323	\$282,719	\$279,691
Cost of net revenues:				
Product and supply costs	37,443	38,600	70,343	74,297
Patient service equipment depreciation	12,923	11,991	27,583	23,638
Operating costs	5,280	5,899	11,293	11,861
Total cost of net revenues	55,646	56,490	109,219	109,796
Provision for doubtful accounts	5,117	4,153	9,979	8,586
Selling, general and administrative	76,277	74,701	154,567	150,970
Depreciation and amortization	3,221	3,296	6,741	7,387
Restructuring expense	1,929	—	1,929	—
Total costs and expenses	142,190	138,640	282,435	276,739
Operating income	2,216	5,683	284	2,952
Interest expense, net	12,204	12,028	24,612	22,095
Other (income) expense, net	(4)	(2)	2	48
Loss on extinguishment of debt	—	2	—	12,171
Loss before income taxes	(9,984)	(6,345)	(24,330)	(31,362)
Federal and state income tax expense (benefit)	156	233	(242)	(3,028)
Net loss	(10,140)	(6,578)	(24,088)	(28,334)
Accrued dividends on redeemable preferred stock	113	113	225	225
Net loss attributable to common stockholders	<u>\$ (10,253)</u>	<u>\$ (6,691)</u>	<u>\$ (24,313)</u>	<u>\$ (28,559)</u>

The following table shows our results of operations as a percentage of our net revenues for the three and six months ended June 30, 2008 and 2007.

	<u>Three months ended</u> <u>June 30,</u>		<u>Six months ended</u> <u>June 30,</u>	
	<u>2008</u>	<u>2007</u>	<u>2008</u>	<u>2007</u>
Net revenues	100.0%	100.0%	100.0%	100.0%
Cost of net revenues:				
Product and supply costs	25.9%	26.7%	24.9%	26.6%
Patient service equipment depreciation	8.9%	8.3%	9.8%	8.5%
Operating costs	3.7%	4.1%	4.0%	4.2%
Total cost of net revenues	38.5%	39.1%	38.7%	39.3%
Provision for doubtful accounts	3.5%	2.9%	3.5%	3.1%
Selling, general and administrative	52.8%	51.8%	54.7%	54.0%
Depreciation and amortization	2.2%	2.3%	2.4%	2.6%
Restructuring expense	1.3%	— %	0.7%	— %
Total costs and expenses	98.3%	96.1%	100.0%	99.0%
Operating income	1.7%	3.9%	— %	1.0%
Interest expense, net	8.5%	8.3%	8.7%	7.9%
Other (income) expense, net	— %	— %	— %	— %
Loss on extinguishment of debt	— %	— %	— %	4.4%
Loss before income taxes	(6.8)%	(4.4)%	(8.7)%	(11.3)%
Federal and state income tax expense (benefit)	0.1%	0.2%	(0.1)%	(1.1)%
Net loss	(6.9)%	(4.6)%	(8.6)%	(10.2)%
Accrued dividends on redeemable preferred stock	0.1%	0.1%	0.1%	0.1%
Net loss attributable to common stockholders	(7.0)%	(4.7)%	(8.7)%	(10.3)%

Three months ended June 30, 2008 as compared to the three months ended June 30, 2007

Total net revenues for the three months ended June 30, 2008 were \$144.4 million as compared to \$144.3 million for the comparable period in 2007. We estimate that the increase in net revenues of \$0.1 million was comprised of 6.0% internal growth offset by Medicare price reductions of approximately 5.9% taking effect in 2008. Our internal growth is predominantly in our core oxygen and CPAP business, while Medicare price reductions have primarily impacted net revenues associated with nebulizer medications.

Net revenues for the three months ended June 30, 2008, were impacted by a change in ordering patterns for certain inhalation drugs by customers concerned about the potential loss of Medicare coverage of these drugs. In April of this year, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) issued a revision of the Nebulizer Local Coverage Determination (LCD) that would have effectively eliminated Medicare reimbursement and patient access to these medications as of July 1, 2008. In response to this potential loss of access, a significant number of our customers placed orders in June to receive a 90-day shipment of these drugs rather than a 30-day shipment. The net effect of this change in ordering patterns was to accelerate approximately \$6.3 million of revenues in the second quarter that would otherwise be expected to occur in the third quarter. The Centers for Medicare and Medicaid Services (CMS) subsequently issued instructions to the DME MACs to delay the implementation of the LCD until November 1, 2008. Given the uncertainty with respect to future access to these medications after November 1, 2008, we expect that our pharmacy customers will again place orders to receive a 90-day drug shipment during the third quarter of 2008.

Cost of net revenues totaled \$55.6 million for the three months ended June 30, 2008, a decrease of \$0.8 million, or 1.5%, from the comparable period in 2007. The net decrease was primarily attributable to lower overall product and supply costs from changes in nebulizer medication product mix, offset by increased product costs incurred with the 90-day DuoNeb shipments in June 2008 as described above and increased depreciation on patient service equipment as a result of the shortening of the average estimated useful life from five years to four years. Cost of net revenues as a percentage of net revenue was 38.5% for the three months ended June 30, 2008 as compared to 39.1% for the comparable period in 2007.

The provision for doubtful accounts for the three months ended June 30, 2008 totaled \$5.1 million, a \$1.0 million increase from the comparable period in 2007. This increase was attributable to a slightly higher rate of bad debt associated with the collection of patient co-payments and deductibles.

Selling, general and administrative expenses for the three months ended June 30, 2008 totaled \$76.3 million, an increase of \$1.6 million, or 2.1%, from the comparable period in 2007. The increases in selling, general and administrative expenses were consistent with normal cost of living increases in employee-related costs, in addition to a 21.0% increase in fuel costs. Selling, general and administrative expenses as a percentage of net revenues increased to 52.8% for the three months ended June 30, 2008 from 51.8% for the three months ended June 30, 2007.

Depreciation and amortization for the three months ended June 30, 2008 totaled \$3.2 million, a decrease of \$0.1 million, or 2.3%, from the comparable period in 2007. 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 2.2% as compared to 2.3% for the comparable period in 2007.

Restructuring expense for the three months ended June 30, 2008 totaled \$1.9 million. In response to the significant reductions in Medicare reimbursement for nebulizer medications, we have substantially completed a restructuring of our clinical programs and pharmacy operations. We believe that the changes associated with this restructuring will allow us to continue offering mail-order nebulizer medications to our patients absent any further significant reductions in Medicare reimbursement for these products.

Net interest expense for the three months ended June 30, 2008 totaled \$12.2 million, an increase of \$0.2 million, or 1.5%, from the comparable period in 2007. The increase is primarily attributable to an increase of approximately \$20.2 million in the average debt outstanding during the three months ended June 30, 2008 as compared to the comparable period in 2007, partially offset by a decrease of approximately 177 basis points in the average applicable variable interest rates.

Federal and state income tax expense for the three months ended June 30, 2008 was consistent with the amount for the comparable period in 2007. No federal tax benefit was recognized from the operating losses for either period. The net income tax expense relates to state tax liabilities from states requiring separate return filing or states which have minimum taxes based on business activity other than net income.

Net loss for the three months ended June 30, 2008 was \$10.1 million compared to a net loss of \$6.6 million for the comparable period in 2007. This \$3.6 million increase in our net loss is primarily attributable to the \$1.9 million restructuring expense and increased fuel costs.

Six months ended June 30, 2008 as compared to the six months ended June 30, 2007

Total net revenues for the six months ended June 30, 2008 were \$282.7 million as compared to \$279.7 million for the comparable period in 2007. We estimate that the increase in net revenues was comprised of 5.6% internal growth offset by Medicare price reductions of approximately 4.4% taking effect in 2008. Our internal growth is predominantly in our core oxygen and CPAP business, while Medicare price reductions have primarily impacted net revenues associated with nebulizer medications.

Net revenues for the six months ended June 30, 2008, were impacted by a change in ordering patterns for certain inhalation drugs by customers concerned about the potential loss of Medicare coverage of these drugs. In April of this year, the DME MACs issued a revision of the Nebulizer LCD that would have effectively eliminated Medicare reimbursement and patient access to these medications as of July 1, 2008. In response to this potential loss of access, a significant number of our customers placed orders in June to receive a 90-day shipment of these drugs rather than a 30-day shipment. The net effect of this change in ordering patterns was to accelerate approximately \$6.3 million of revenues in the second quarter that would otherwise be expected to occur in the third quarter. CMS subsequently issued instructions to the DME MACs to delay the implementation of the LCD until November 1, 2008. Given the uncertainty with respect to future access to these medications after November 1, 2008, we expect that our pharmacy customers will again place orders to receive a 90-day drug shipment during the third quarter of 2008.

Cost of net revenues totaled \$109.2 million for the six months ended June 30, 2008, a decrease of \$0.6 million, or 0.5%, from the comparable period in 2007. The net decrease was primarily attributable lower product and supply costs attributable to changes in nebulizer medication product mix, offset by increased product costs incurred with the 90-day DuoNeb shipments in June 2008 as described above and increased depreciation on patient service equipment as a result of the shortening of the average estimated useful life of such equipment from five years to four years. Cost of net revenues as a percentage of net revenue was 38.7% for the six months ended June 30, 2008 as compared to 39.3% for the comparable period in 2007.

The provision for doubtful accounts for the six months ended June 30, 2008 totaled \$10.0 million, a \$1.4 million increase from the comparable period in 2007. This increase was attributable to a slightly higher rate of bad debt associated with the collection of patient co-payments and deductibles.

Selling, general and administrative expenses for the six months ended June 30, 2008 totaled \$154.6 million, an increase of \$3.6 million, or 2.4%, from the comparable period in 2007. The increases in selling, general and administrative expenses were consistent with normal cost of living increases in employee-related costs, in addition to a 24.4% increase in fuel costs. Selling, general and administrative expenses as a percentage of net revenues increased to 54.7% for the six months ended June 30, 2008 from 54.0% for the six months ended June 30, 2007.

Depreciation and amortization for the six months ended June 30, 2008 totaled \$6.7 million, a decrease of \$0.6 million, or 8.8%, from the comparable period in 2007. 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 2.4% as compared to 2.6% for the comparable period in 2007.

Restructuring expense for the three months ended June 30, 2008 totaled \$1.9 million. In response to the significant reductions in Medicare reimbursement for nebulizer medications, we have substantially completed a restructuring of our clinical programs and pharmacy operations. We believe that the changes associated with this restructuring will allow us to continue offering mail-order nebulizer medications to our patients absent any further significant reductions in Medicare reimbursement for these products.

Net interest expense for the six months ended June 30, 2008 totaled \$24.6 million, an increase of \$2.5 million, or 11.4%, from the comparable period in 2007. The increase is primarily attributable to an increase of approximately \$59.1 million in the average debt outstanding during the six months ended June 30, 2008 as compared to the comparable period in 2007, partially offset by a decrease of approximately 32 basis points in the average applicable variable interest rates.

We recorded a loss on extinguishment of debt for the six months ended June 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. We did not incur any comparable expenses during the six months ended June 30, 2008.

Federal and state income tax benefit for the six months ended June 30, 2008 decreased to \$0.2 million from \$3.0 million for the comparable period in 2007. This decrease in tax benefit is primarily the result of a lower effective beneficial tax rate for the six months ended June 30, 2008 due to non-recognition of future benefits of current period losses.

Net loss for the six months ended June 30, 2008 was \$24.1 million compared to a net loss of \$28.3 million for the six months ended June 30, 2007. As outlined above, this \$4.2 million decrease in our net loss is primarily attributable to the non-recurring prior year loss on extinguishment of debt, which contributed \$12.2 million to the net loss for the six months ended June 30, 2007, offset by increased interest expense, the \$1.9 million restructuring expense and increased fuel costs.

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

Net cash provided by operating activities was \$17.9 million for the six months ended June 30, 2008, as compared to \$12.2 million for the same period in 2007. Cash flows and cash on hand were sufficient to fund operations, capital expenditures and required repayments of debt during the six months ended June 30, 2008.

Accounts receivable before allowance for doubtful accounts increased to \$86.3 million at June 30, 2008 from \$84.6 million at December 31, 2007. Allowances for contractual adjustments and doubtful accounts as a percentage of accounts receivable totaled 29.2% and 31.5% as of June 30, 2008 and December 31, 2007, 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 50.0 days at June 30, 2008 and December 31, 2007. The following table sets forth the percentage breakdown of our accounts receivable by payer and aging category as of June 30, 2008 and December 31, 2007:

June 30, 2008

<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	45.1%	21.1%	2.9%	69.1%
Aged 91-180 days	6.0%	5.8%	3.1%	14.9%
Aged 181-360 days	4.4%	4.6%	2.0%	11.0%
Aged over 360 days	1.9%	2.1%	1.0%	5.0%
Total	57.4%	33.6%	9.0%	100.0%

December 31, 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	35.2%	27.6%	2.8%	65.6%
Aged 91-180 days	5.6%	7.4%	2.4%	15.4%
Aged 181-360 days	5.4%	6.8%	2.6%	14.8%
Aged over 360 days	2.1%	1.7%	0.4%	4.2%
Total	48.3%	43.5%	8.2%	100.0%

Included in accounts receivable are earned but unbilled receivables of \$24.5 million at June 30, 2008 and \$25.1 million at December 31, 2007. These amounts include \$3.6 million at June 30, 2008 and \$4.5 million at December 31, 2007 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, 2007, we had \$3.5 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. 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, the Deficit Reduction Act of 2005 and future legislation.

Net cash used in investing activities was \$26.6 million for the six months ended June 30, 2008, as compared to \$36.9 million for the same period in 2007. 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 \$26.6 million for the six months ended June 30, 2008 as compared to \$24.4 million for the same period in 2007. The increase in 2008 capital expenditures is primarily attributable to patient growth and changes in the Medicare capped rental period, specifically for CPAP. During the six months ended June 30, 2007, we collateralized our letters of credit with restricted cash deposits of \$12.5 million. There were no businesses acquired during the six months ended June 30, 2008 and 2007.

Cash flows provided by financing activities primarily relate to the refinancing of our former senior secured credit facility. On March 30, 2007, we entered into a credit agreement (the "Credit Agreement") with the lenders party 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 based on 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. 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.

As of June 30, 2008, we had the following debt facilities and outstanding debt:

- \$203.1 million Senior Facility described above. As of June 30, 2008, the entire amount of the term loan was outstanding. As of June 30, 2008, the term loan bears interest at 9.0% (Eurodollar rate plus 6.0%). We have not elected to pay any such interest in cash since inception of the Senior Facility. Accordingly, during the six months ended June 30, 2008, a total of \$10.7 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 \$203.1 million as of June 30, 2008. Accrued interest on the Senior Facility totaled \$3.1 million at June 30, 2008 and \$3.6 million at December 31, 2007.
- \$300.0 million aggregate principal amount of 9 1/2% 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 1/2% is payable semi-annually in arrears on April 1 and October 1 of each year. As of both June 30, 2008 and December 31, 2007, we had a balance of \$287.0 million outstanding. We made our regularly scheduled April 1 interest payment of \$13.6 million during the six months ended June 30, 2008. Accrued interest on the senior subordinated notes totaled \$6.8 million at both June 30, 2008 and December 31, 2007.

During the six months ended June 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 six months ended June 30, 2007 was \$2.6 million. 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.

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 \$12.2 million as of June 30, 2008, which are cash collateralized at 105% of their face amount. The cash collateral for these outstanding letters of credit is included in the \$13.3 million of restricted cash in our consolidated balance sheet as of June 30, 2008.

At June 30, 2008, we had current assets of \$144.2 million and current liabilities of \$65.2 million, resulting in working capital of \$79.0 million and a current ratio of 2.2x. 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, 2008. 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 during the next twelve months.

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. 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, 2007.

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, 2007.

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 relatively 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 the applicable useful life under a straight-line convention, without specific physical tracking of individual items. Each grouping of patient service equipment is assigned a useful life intended to provide proper matching of the cost of patient service equipment with the patient service revenues generated from use of the equipment, when considering the conversion of rental equipment to purchase, wear and tear, damage, loss and ultimately scrapping of patient service equipment over its life. Effective January 1, 2008, we shortened the average useful life on patient service equipment from five years to four years. This reduction in the estimated useful life of our patient service equipment is largely attributable to shortened rent to purchase periods, as a result of provisions included in the Deficit Reduction Act of 2005 that reduced the capped rental period for certain types of home medical equipment, including continuous positive airway pressure (CPAP) devices, from 15 months to 13 months beginning January 1, 2007, and increased volume on certain types of durable medical and respiratory equipment, which result in an increased percentage of our patient service equipment converting to purchase. Whenever events or circumstances occur which change the estimated useful life of an asset, we account for the change prospectively. While we believe our current estimates of useful lives are reasonable, significant differences in actual experience or significant changes in assumptions may cause additional changes to future depreciation expense. On July 15, 2008, the United States Congress, following an override of a Presidential veto, enacted the Medicare Improvement for Patients and Providers Act of 2008 (H.R. 6331). H.R. 6331 repeals the transfer of title to oxygen equipment at the end of the 36-month rental cap. We will be evaluating the impact of this policy change on the useful life assigned to the associated equipment. Any change in useful life resulting from H.R. 6331 will be reflected prospectively beginning July 1, 2008.

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 increased cost of transportation related to rising fuel prices; 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, 2007 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 June 30, 2008, we have \$203.1 million outstanding under our payment-in-kind senior secured term loan. This term loan bears interest at a variable rate based upon 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 \$203.1 million outstanding balance on the term loan, we would incur approximately \$2.0 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 in recording, processing, summarizing and reporting, on a timely basis, information required to be disclosed by us in our reports that we file or submit under the Exchange Act.

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 first quarter of fiscal year 2008 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

On May 16, 2008, we entered into a Corporate Integrity Agreement (the “2008 CIA”) with the OIG in connection with the resolution of a previously reported qui tam complaint brought by one of our former employees. The action was filed on April 6, 2004 and alleged violations of the False Claims Act between February 22, 1996 and April 30, 2003. In settling the litigation, we did not admit wrongdoing but paid \$2.0 million plus interest to the United States Treasury Department and \$1.4 million to the former employee for expenses and attorney’s fees and costs. The settlement amount was paid on May 19, 2008; the associated expense was previously recorded as legal settlement in the statement of operations for the three months and year ended December 31, 2007.

Other information related to our legal proceedings 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 I 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, 2007 and the Company’s Quarterly Report on Form 10-Q for the quarter ended March 31, 2008.

Risks related to our liquidity and our financing and capital structures

Trading on the OTC Bulletin Board may be volatile and sporadic, which could depress the market price of our common stock and make it difficult for our stockholders to resell their shares.

Our common stock is currently quoted on the OTC Bulletin Board, a service sponsored and operated by The Financial Industry Regulatory Authority (FINRA), which is an inter-dealer automated quotation system for equity securities not included in the NASDAQ Stock Market. Trading in stock quoted on the OTC Bulletin Board is often thin and characterized by wide fluctuations in trading prices, due to many factors that may have little to do with our operations or business prospects. This volatility could depress the market price of our common stock for reasons unrelated to operating performance. Moreover, the OTC Bulletin Board is not a stock exchange, and trading of securities on the OTC Bulletin Board is often more sporadic than the trading of securities listed on a quotation system like NASDAQ or a stock exchange like Amex. Accordingly, shareholders may have difficulty reselling any of the shares. In addition, as an OTC Bulletin Board listed company, we do not attract the extensive analyst coverage that accompanies companies listed on NASDAQ or any other regional or national exchange. Further, institutional and other investors may have investment guidelines that restrict or prohibit investing in securities traded in the over-the-counter market. These and other factors may have an adverse impact on the trading and price of our securities, and may make it difficult for our stockholders to sell their shares in the open market when eligible to do so.

The wide fluctuations in trading prices, as well as general economic, market and political conditions such as interest rate increases, recessions or military or political conflicts, may materially and adversely affect the market price of our common stock, thereby causing you to lose some or all of your investment.

Our stock is a penny stock. Trading of our stock may be restricted by the SEC’s penny stock regulations and FINRA’s sales practice requirements, which may limit a stockholder’s ability to buy and sell our stock.

Our stock is a penny stock. The Securities and Exchange Commission has adopted Rule 3a51-1 which generally defines “penny stock” to be any equity security that has a market price (as defined) less than \$5.00 per share or an exercise price of less than \$5.00 per share, subject to certain exceptions. Our securities are covered by the penny stock rules, including Rule 15c-9, which impose additional sales practice requirements on broker-dealers who sell to persons other than established customers and “accredited investors.” The term “accredited investor” refers generally to institutions with assets in excess of \$5,000,000 or individuals with a net worth, or joint net worth with the person’s spouse, that exceeds \$1,000,000 or annual income exceeding \$200,000 or \$300,000 jointly with their spouse. The penny stock rules require a broker-dealer, prior to a transaction in a penny stock not otherwise exempt from the rules, to deliver a standardized risk disclosure document in a form prepared by the SEC which provides information about penny stocks and the nature and level of risks in the penny stock market. The broker-dealer also must provide the customer with current bid and offer quotations for the penny stock, the compensation of the broker-dealer and its salesperson in the transaction and monthly account statements showing the market value of each penny stock held in the customer’s account. The bid and offer quotations, and the broker-dealer and salesperson compensation information, must be given to the customer orally or in writing prior to effecting the transaction and must be given to the customer in writing before or with the customer’s confirmation. In addition, the penny stock rules require that prior to a transaction in a penny stock not otherwise exempt from these rules, the broker-dealer must make a special written determination that the penny stock is a suitable investment for the purchaser and receive the purchaser’s written agreement to the transaction. These disclosure requirements may have the effect of reducing the level of trading activity in the secondary market for the stock that is subject to these penny stock rules. Consequently, these penny stock rules may affect the ability of broker-dealers to trade our securities. We believe that the penny stock rules discourage investor interest in and limit the marketability of our common stock, and some investors may perceive our securities to be less attractive because they are traded in the over-the-counter market.

In addition to the “penny stock” rules promulgated by the Securities and Exchange Commission, FINRA has adopted rules that require that in recommending an investment to a customer, a broker-dealer must have reasonable grounds for believing that the investment is suitable for that customer. Prior to recommending speculative low priced securities to their non-institutional customers, broker-dealers must make reasonable efforts to obtain information about the

customer's financial status, tax status, investment objectives and other information. Under interpretations of these rules, FINRA believes that there is a high probability that speculative low priced securities will not be suitable for at least some customers. The FINRA requirements make it more difficult for broker-dealers to recommend that their customers buy our common stock, which may limit your ability to buy and sell our stock.

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

A significant percentage of our business is derived from the sale of Medicare-covered respiratory medications, and recent legislation imposed significant reductions in Medicare reimbursement for such inhalation drugs.

Historically, prescription drug coverage under Medicare has been limited to drugs furnished incident to a physician's services and certain self-administered drugs, including inhalation drug therapies. Prior to the MMA, Medicare reimbursement for covered Medicare Part B drugs, including inhalation drugs that we provide, was limited to 95 percent of the published average wholesale price (AWP) for the drug. The MMA established new payment limits and procedures for drugs reimbursed under Medicare Part B. Beginning in 2005, inhalation drugs furnished to Medicare beneficiaries were reimbursed at 106 percent of the volume-weighted average sales price (ASP) of the drug, as determined from data provided each quarter by drug manufacturers under a specific formula described in the MMA. Implementation of the ASP-based formula resulted in a dramatic reduction in payment rates for inhalation drugs in 2005 and beyond.

Furthermore, because the ASP amounts vary from quarter to quarter, changes in market forces influence the Medicare payment rate. In late 2006, the US Food and Drug Administration approved a first-time generic formulation for DuoNeb. The introduction of this generic product into the market has contributed to the reduction of the ASP for DuoNeb from \$1.079 in the fourth quarter of 2007 to \$0.805 in the first quarter of 2008, \$0.830 in the second quarter of 2008, and \$0.581 in the third quarter of 2008. We estimate that this reduction in ASP for DuoNeb will reduce our revenue by approximately \$2.7 million per quarter as compared to the fourth quarter of 2007. The impact of this reduction to our profit margins, profitability, operating cash flows and results of operations is partially mitigated through the dispensing of generic DuoNeb.

Recently enacted legislation will further affect Medicare reimbursement amounts for covered Medicare Part B drugs, including inhalation drugs that we provide, beginning April 1, 2008. The SCHIP Extension Act requires CMS to apply an alternative volume weighting computation to its calculation of ASP-based payment amounts. Implemented on April 1, 2008, the new calculation methodology resulted in lower reimbursement amounts for certain inhalation drugs. The SCHIP Extension Act also specifically lowers reimbursement for the inhalation drug albuterol. The Congressional Budget Office (CBO) estimates that the provisions of the SCHIP Extension Act affecting Medicare Part B drug reimbursement will result in reductions in aggregate Medicare outlays for such drugs of \$1.0 billion over five years and \$2.6 billion over 10 years. The reimbursement rate for a single dose albuterol was reduced from \$1.105 in the first quarter of 2008 to \$0.110 in the second quarter and \$0.100 in the third quarter of 2008. This reduction in the reimbursement rate for single dose albuterol could have a material adverse effect on our revenues, profit margins, profitability, operating cash flows and results of operations.

Recent regulatory changes subject the Medicare reimbursement rates for our equipment and services to additional reductions and to potential discretionary adjustment by CMS, which could reduce our revenues, net income and cash flows.

The BBA granted authority to the Secretary of the Department of Health and Human Services (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 regulation 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 the Centers for Medicare and Medicaid Services (CMS) and its contractors (the Durable Medical Equipment Medicare Administrative Contractors or DME MACs) 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. The implementation of the inherent reasonableness procedure itself does not trigger payment adjustments for any items or services and to date, no payment adjustments have occurred or been proposed under this inherent reasonableness procedure.

In addition to its inherent reasonableness authority, CMS contractors have the discretion to reduce the reimbursement for home medical equipment (HME) 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 (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.

On April 10, 2008, the DME MACs issued a local coverage determination that would cause further reductions in payments for certain drugs. Specifically, effective for claims with dates of service on or after July 1, 2008, claims for non-compounded levalbuterol and DuoNeb were to be paid based on the allowance for “the least costly medically appropriate alternative.” For levalbuterol, payment would be based on non-compounded albuterol. Claims for DuoNeb would be based on the individual non-compounded unit dose vials of albuterol and ipratropium. However, on June 12, 2008, CMS instructed the DME MACs to withdraw the least costly alternative policy for levalbuterol until receipt of further guidance from CMS. In addition, on June 20, 2008, CMS delayed implementation of least costly alternative policies with respect to DuoNeb until November 1, 2008. We cannot predict the ultimate resolution of these least costly alternative policies; however, based upon current volumes, we estimate that, if implemented, the changes in reimbursement for levalbuterol and DuoNeb would further reduce our revenue by approximately \$4.7 million per quarter.

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

Recent legislation (see “Business—Government Regulation—Medicare Laws and Regulations” in Part I, Item 1 above) instructs CMS to establish and implement programs under which competitive bidding areas (CBAs) will be established throughout the United States for contract award purposes for the furnishing of competitively priced items of DME, including oxygen equipment. We had been awarded contracts for 9 of the 10 CBAs. On July 15, 2008, however, the United States Congress, following an override of a Presidential veto, enacted the Medicare Improvement for Patients and Providers Act of 2008 (H.R. 6331), which retroactively delays the implementation of competitive bidding for eighteen months and terminates all existing contracts previously awarded. CMS is expected to publish further guidance as to the implications of the new legislation. In the meantime, those items selected for competitive acquisition for round one will be paid under the fee schedules, although, effective January 1, 2009, H.R. 6331 decreased 2008 fee schedule payment amounts by 9.5 percent for product categories included in competitive bidding. Based on current product volumes, management estimates that H.R. 6331 will negatively impact our annual revenue and net income by approximately \$17.0 million. 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 full impact of competitive bidding, nor can we predict the effect the process will have on our ability to continue to provide products to Medicare beneficiaries.

Proposed surety bond requirements could result in significant additional cost in operating our business.

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 the BBA. 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 sought 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 such an exemption, if any, would be available to us. If this proposal were enacted and if no such exemption is included, or if such an exemption, if any, is not made available to us, then we would be required to obtain surety bonds for each of our approximately 500 locations, resulting in significant additional cost in operating our business.

On February 7, 2008 a bill was introduced in the Senate (S.2603 – Medicare Fraud Prevention Act of 2008) to increase the surety bond requirement to \$500,000. Industry representatives have contacted those sponsoring this bill to express concern that the significant cost and cash collateral required for a surety bond of this amount would penalize law abiding suppliers and could limit services to Medicare beneficiaries. While this bill has not been voted on by the Senate, we cannot predict the outcome of this or any future legislation.

Risks related to the rising cost of transportation and fuel

We depend on ground transportation to deliver medical equipment and if fuel prices increase significantly, our results of operations could be adversely affected.

We depend on ground transportation to deliver medical equipment to our customers. Fuel prices have fluctuated significantly in recent years, and the recent rise in fuel prices has increased our operating expenses. For the six-month period ended June 30, 2008, we experienced a 24.4% increase in fuel costs. Fuel prices and availability of all petroleum products are subject to political, economic and market factors that are beyond our control. A further increase in fuel prices could additionally adversely affect our results of operations. We have not experienced a lack of available fuel but could be adversely impacted if a fuel shortage were to develop. The total impact of higher energy prices on other nonfuel-related expenses is difficult to ascertain. We cannot predict future fuel price fluctuations or the impact of higher energy prices on other cost elements. Depending upon the rates of these changes and the impact on costs in other fuel- and energy-related areas, our profit margins, profitability, operating cash flows and results of operations could be further impacted.

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

The Company's annual meeting of stockholders was held on June 24, 2008. At the meeting, the stockholders:

- (1) elected the following six persons to serve as directors of the Company: Arthur J. Reimers, Philip L. Carter, James H. Bloem, Edward L. Kuntz and Arthur Siegel;
- (2) ratified the appointment of Deloitte & Touche LLP as the Company's independent registered public accounting firm for the fiscal year ending December 31, 2008.

The number of votes cast for, against or withheld, and the number of abstentions with respect to each such matter is set forth below.

<u>MATTER</u>	<u>FOR</u>	<u>AGAINST/ WITHHELD</u>	<u>ABSTAINED</u>
(1) Election of Directors:			
Arthur J. Reimers	20,471,548	492,582	—
Philip L. Carter	20,473,298	490,832	—
James H. Bloem	20,331,948	632,182	—
Edward L. Kuntz	20,273,394	690,786	—
Arthur Siegel	20,331,948	632,182	—
(2) Ratification of Independent Registered Public Accounting Firm	20,511,167	320,401	132,562

ITEM 5—Other Information

Effective June 12, 2008, the Company's common stock was de-listed from the NASDAQ Stock Market and subsequently became eligible for quotation on the OTC Bulletin Board under the symbol ROHI.OB. The OTC Bulletin Board is a service sponsored and operated by The Financial Industry Regulatory Authority that displays real-time quotes, last sale prices and volume information in over-the-counter securities.

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.
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.

Ratio of Earnings to Fixed Charges
Rotech Healthcare Inc.
(In thousands)

	Six months Ended June 30, 2008	2007	2006	2005	2004
<i>Ratio of Earnings to fixed charges</i>					
Pretax (loss) earnings from continuing operations	\$(24,330)	\$(50,823)	\$(572,907)	\$ 9,159	\$ 63,574
Add:					
Fixed charges	30,584	58,548	46,178	41,039	41,253
Total Earnings (Loss) (A)	<u>\$ 6,254</u>	<u>\$ 7,725</u>	<u>\$(526,729)</u>	<u>\$50,198</u>	<u>\$104,827</u>
Interest Expense	\$ 25,511	\$ 48,836	\$ 36,907	\$32,694	\$ 33,967
Estimate of the interest within rental expense	5,073	9,712	9,271	8,345	7,286
Total Fixed Charges (B)	<u>\$ 30,584</u>	<u>\$ 58,548</u>	<u>\$ 46,178</u>	<u>\$41,039</u>	<u>\$ 41,253</u>
Ratio (A/B)	<u>0.20x</u>	<u>0.13x</u>	<u>(11.41)¹x</u>	<u>1.22x</u>	<u>2.54x</u>

¹ 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 June 30, 2008 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: August 8, 2008

/s/ PHILIP L. CARTER

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 June 30, 2008 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: August 8, 2008

/s/ STEVEN P. ALSENE

Steven P. Alsene
Chief Financial Officer

**Certification Pursuant to
18 U.S.C. Section 1350,
As Adopted Pursuant to
Section 906 of the Sarbanes-Oxley Act of 2002**

In connection with the Quarterly Report on Form 10-Q of Rotech Healthcare Inc. (the "Company") for the quarterly period ended June 30, 2008, as filed with the Securities and Exchange Commission (the "Report"), Philip L. Carter, as President and Chief Executive Officer of the Company, and Steven P. Alsene, as Chief Financial Officer of the Company, each hereby certifies, pursuant to 18 U.S.C. §1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that, to the best of each such officer's knowledge:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ PHILIP L. CARTER

Name: Philip L. Carter
Title: **President and Chief Executive Officer**
Date: **August 8, 2008**

/s/ STEVEN P. ALSENE

Name: Steven P. Alsene
Title: **Chief Financial Officer**
Date: **August 8, 2008**

This certification accompanies the Report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended.

A signed original of this written statement required by Section 906 of the Sarbanes-Oxley Act of 2002 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.