CORAM HEALTHCARE CORP
Form 10-K/A
May 20, 2003

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

FORM 10-K/A
AMENDMENT No.1

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

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2002
COMMISSION FILE NUMBER 1-11343

CORAM HEALTHCARE CORPORATION
(Exact name of registrant as specified in its charter)

DELAWARE	33-0615337
(State or other jurisdiction of Incorporation or organization)	(IRS Employer Identification No.)
1675 BROADWAY, SUITE 900 DENVER, COLORADO	80202
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (303) 292-4973

Securities registered pursuant to Section 12(b) of the Act: None

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

TITLE OF EACH CLASS	NAME OF EACH EXCHANGE ON WHICH REGISTERED
Common Stock ($0.001 par value per share)	Over the Counter Bulletin Board

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 and (2) has been subject to such filing requirements for the past 90 days. Yes [X] No [ ]

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K/A or any amendment to this Form 10-K/A [ ]

Indicate by check mark whether the registrant has filed all documents and reports required to be filed by Sections 12, 13 or 15(d) of the Securities Exchange Act of 1934 subsequent to the distribution of securities under a plan confirmed by a court. Yes [ ] No [ ] (On August 8, 2000, the registrant and one of its wholly-owned subsidiaries filed voluntary petitions under Chapter 11 of

Title 11 of the United States Code in the Bankruptcy Court for the District of Delaware. Through April 11, 2003, no plan or plans of reorganization have been confirmed by such court.)

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 under the Act). Yes [ ] No [X]

As of April 11, 2003, there were outstanding 49,638,452 shares of the registrant's common stock, which is the only class of voting stock of the registrant outstanding. As of June 28, 2002, the aggregate market value of the shares of common stock held by nonaffiliates of the registrant based on the closing price for the common stock on the Over the Counter Bulletin Board on such date, was approximately $31.3 million.

DOCUMENTS INCORPORATED BY REFERENCE
None

STATEMENT OF FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K/A contains certain "forward-looking" statements (as such term is defined in the Private Securities Litigation Reform Act of 1995) and information relating to Coram Healthcare Corporation ("CHC") and its subsidiaries (collectively "Coram" or the "company") that are based on the beliefs of Coram's management, as well as, assumptions made by and information currently available to management. When used in this report, the words "estimate," "project," "believe," "anticipate," "intend," "expect" and similar expressions are intended to identify forward-looking statements. Coram's actual results may vary materially from the forward-looking statements made in this report due to important factors, including, but not limited to: the uncertainties related to the ongoing bankruptcy proceedings of CHC and its first tier wholly-owned subsidiary, Coram, Inc. ("CI"), including actions taken by the appointed Chapter 11 trustee (Arlin M. Adams, Esquire) and parties who may be adverse to the bankruptcy estates; Coram's ability to maintain continued compliance with the provisions of the Omnibus Budget Reconciliation Act of 1993 (commonly referred to as "Stark II"); Coram's absence of sustained profitability; uncertainties associated with the outcomes of certain pending legal proceedings; the company's leveraged financial structure, including significant liquidation preferences relating to certain CI preferred stock securities; the company's need to obtain additional financing or equity; the company's ability to obtain necessary financing to fund a pending settlement with the Internal Revenue Service; uncertainties associated with the dilution that would occur if the company's existing debt holders exercise their equity conversion rights; the company's limited liquidity; the company's ability to successfully implement significant additions to or modifications of its company-wide information systems; the company's need for financing related to additions to, and upgrades of, current information technology systems; the company's ability to obtain adequate funding for and successfully deploy certain critical replacement infusion pumps and related tubing sets for certain products that have been discontinued by a vendor; the company's dependence upon the prices paid by third-party payers for the company's services; adverse changes in the average wholesale prices paid for drugs that Coram provides to its patients; uncertainties associated with changes in state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the impact on healthcare service businesses, as well as, enhanced regulatory oversight of the healthcare industry; and certain other factors, all of which are described in greater detail in this report in Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors." Readers are cautioned not to place undue reliance on these forward-looking statements, which speak only as of the date hereof. Management does not undertake any obligation to publicly 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.

PART I

ITEM 1. BUSINESS

GENERAL OVERVIEW

Lines of Business. During the three years ended December 31, 2002, Coram was engaged primarily in the business of furnishing alternate site (outside the hospital) infusion therapy and related services, including non-intravenous home health products such as respiratory therapy services and related equipment and durable medical equipment. Other services offered by Coram include outsourced hospital compounding services and centralized management, administration and clinical support for clinical research trials and, through July 31, 2000, pharmacy benefit management and specialty mail order pharmacy services. See Note 17 to the company's Consolidated Financial Statements for further discussion of the company's industry segments.

Coram's primary business strategy is to focus its efforts on the delivery of its core infusion therapies, such as nutrition, anti-infective therapies, pain management, intravenous immunoglobulin ("IVIG"), therapies for persons receiving transplants and coagulant and blood clotting therapies for persons with hemophilia. Management has implemented programs focused on the reduction and control of the costs of providing services and operating expenses, assessment of under-performing branches and review of branch efficiencies. In connection therewith, several branches have been closed or scaled back to serve as satellites for other branches and personnel have been eliminated (see Note 6 to the company's Consolidated Financial Statements). Most of the company's alternate site infusion therapy net revenue is derived from third-party payers such as private indemnity insurers, managed care organizations and governmental payers. Management's objective is to continue to provide services that consistently achieve desired clinical outcomes and maintain Coram's consistently high level of patient satisfaction while focusing on disciplined enhancements to the service model. By establishing best demonstrated practice benchmarks for nursing, pharmacy and clinical operations personnel, cost reductions have been achieved while simultaneously improving the quality and consistency of care. Furthermore, management continues to concentrate on reimbursement for services rendered by enhancing billing procedures, documentation and cash collections methods, assessing systems support for reimbursement personnel and concentrating Coram's expertise and managerial resources into fewer reimbursement locations.

Prior to August 1, 2000, the company delivered pharmacy benefit management and specialty mail-order pharmacy services through its Coram Prescription Services ("CPS") business, which provided services and mail-order prescription drugs for chronically ill patients from one primary mail order facility, four satellite mail order facilities and one retail pharmacy. CPS's pharmacy benefit management services were delivered through a network of retail pharmacies, which provided on-line claims administration, formulary management and certain drug utilization review services. CPS's specialty mail-order pharmacy services were delivered through its six facilities, which provided distribution, compliance monitoring, patient education and clinical support to a wide variety of patients. On July 31, 2000, the company completed the sale of CPS to Curascript Pharmacy Services, Inc. and Curascript PBM Services, Inc., which were newly formed affiliates of GTCR Golder Rauner, L.L.C. and are led by certain members of the former CPS management team. See Note 5 to the company's Consolidated

Financial Statements for further details.

While management believes the implementation of its overall business strategy has improved operating performance throughout the company, no assurances can be given as to its ultimate success. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations."

COMPANY HISTORY

Coram was formed on July 8, 1994 as a result of a merger by and among T(2) Medical, Inc., Curaflex Health Services, Inc., Medisys, Inc. and HealthInfusion, Inc., each of which was a publicly-held national or regional provider of home infusion therapy and related services. Coram made a number of acquisitions after commencing operations, the most significant of which was the April 1, 1995 acquisition of certain assets of the home infusion business of Caremark, Inc., a wholly-owned subsidiary of Caremark International, Inc. In addition, effective September 12, 1994, Coram acquired H.M.S.S., Inc., a leading regional provider of home infusion therapies based in Houston, Texas. As a result of these and other acquisitions, Coram became a leading provider of alternate site infusion therapy services in the United States.

CHC and CI (collectively the "Debtors") filed voluntary petitions under Chapter 11 of Title 11 of the United States Code (the "Bankruptcy Code") on August 8, 2000 in the United States Bankruptcy Court for the District of Delaware (the "Bankruptcy Court") In re Coram Healthcare Corporation, Case No. 00-3299 and In re Coram, Inc., Case No. 00-3300 (collectively the "Bankruptcy Cases"). The Bankruptcy Cases have been consolidated for administrative purposes only by the Bankruptcy Court and are being jointly administered under the docket of In re Coram Healthcare Corporation, Case No. 00-3299 (MFW). Commencing on August 8, 2000, the Debtors operated as debtors-in-possession subject to the jurisdiction of the Bankruptcy Court; however, a Chapter 11 trustee was appointed by the Bankruptcy Court on March 7, 2002. With the appointment of a Chapter 11 trustee, the Debtors are no longer debtors-in-possession under Chapter 11 of the Bankruptcy Code. None of the company's other subsidiaries is a debtor in the Bankruptcy Cases and, other than Coram Resource Network, Inc. and Coram Independent Practice Association, Inc. (collectively the "Resource Network Subsidiaries" or "R-Net"), none of the company's other subsidiaries is a debtor in any bankruptcy case. See Note 3 to the company's Consolidated Financial Statements and Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further details.

DELIVERY OF ALTERNATE SITE INFUSION SERVICES

General. Coram delivers its alternate site infusion therapy services through 77 branch offices located in 40 states and Ontario, Canada. Additionally, Coram delivers alternate site infusion therapy services through joint venture and partnership agreements at several other geographic locations. Infusion therapy involves the parenteral administration of nutrition, anti-infective therapies, intravenous immunoglobulin ("IVIG"), coagulant and blood clotting, pain management, chemotherapy and other therapies, as well as, the provision of enteral nutrition.

Infusion patients are primarily referred to Coram following the diagnosis of a specific disease or upon discharge from a hospital. The treating physician generally will determine whether the patient is a candidate for home infusion treatment. Typically, a hospital discharge planner, the patient's physician or a managed care payer will recommend or determine the infusion company to which a patient is referred even though the patient ultimately has the freedom to choose his or her own service provider. Because drugs administered intravenously tend to be more potent and complex than oral drugs, the delivery of intravenous drugs requires patient training, specialized equipment and clinical monitoring by skilled nurses and pharmacists. Many therapies require either a gravity-based

flow control device or an electro-mechanical pump to administer the drugs. Some therapies are administered continuously; however, most are given for prescribed intermittent periods of time. Coram nurses and pharmacists work with the patient's physician to monitor and assess the patient's condition and update the therapy as necessary. The duration of the patient's treatment may last from just a few days to as long as the patient's life.

Branch Facilities. The delivery of infusion services is coordinated through local or regional infusion branches. A typical full service branch provides the following functions:

(i) patient intake and admission;

(ii) sterile product preparation by pharmacists and pharmacy technicians;

(iii) clinical pharmacy services;

(iv) clinical nursing services;

(v) clinical nutrition services;

(vi) collaborative clinical monitoring and disease management;

(vii) materials management, including drug and supply inventory and delivery;

(viii) assistance to specialized reimbursement personnel regarding billing, collections and benefit verification;

(ix) marketing to local referral sources, including doctors, hospitals and payers; and

(x) general management.

A typical full service branch has a fully equipped infusion pharmacy, offices for clinical and administrative personnel and a storage warehouse. It also employs a branch manager, licensed pharmacists, pharmacy technicians, registered nurses, dietitians, and sales and administrative personnel. Such a branch also serves the market area in which it is located, generally within a two-hour driving radius of the patients served, as well as, outlying locations where it can arrange appropriate nursing services. Smaller satellite locations maintain limited supplies and pharmacy operations and are used as support centers to respond to patient needs in specific geographic areas. Coram's full service branches and satellite locations are leased and range from 530 to 32,000 square feet of space, primarily in suburban office parks, often in close proximity to major medical facilities.

In-Home Patient Care. Before accepting a patient for home infusion treatment, the staff at the local branch works closely with the patient's physician or clinician and hospital personnel in order to assess the patient's suitability for home care. This process includes, among other things, assessment of the patient's physical and emotional status, as well as, assessment of certain social factors such as the safety and cleanliness of the home environment and the availability of family members or others to assist in the administration of the patient's therapy, if necessary. Patient review also includes a verification of the patient's eligibility based upon established admissions criteria and the patient's benefits package available from his or her insurance carrier, managed care provider or governmental payer.

When a patient's suitability for home care has been confirmed, the patient and/or their designated carepartner receive training and education concerning the therapy to be administered, including the proper infusion technique and the care and use of intravenous devices and other equipment used in connection with the therapy. The patient and the patient's carepartner are also trained to monitor the patient's response to the therapy in order to identify changes of which the healthcare team should be notified. Nurses employed by or overseen by Coram generally perform the initial patient assessment and training.

Prior to the patient receiving treatment services, the treating physician develops the patient's plan of treatment and communicates it to the local branch's clinical support team, including its nurses and pharmacists. The team develops a plan of care and works with the treating physician and the payer case manager, if applicable, to provide care and to monitor the patient's progress and response to treatment. The Coram pharmacist speaks with the patient or carepartner prior to dispensing the prescribed drugs and performs a prospective review of the patient's condition, medical history and use of other physician-prescribed medications. Throughout the patient's therapy, the local branch's clinical support team will regularly provide the treating physician and the payer case manager with reports on the patient's condition, creating an information flow that allows the treating physician to actively manage the patient's care. The treating physician always directs the patient's care, including changing the plan of treatment in accordance with the patient's needs and responses.

Upon the patient's arrival home, a nurse performs an initial patient assessment, which includes a comprehensive physical examination and environmental assessment. Typically, the administration of the patient's first home infusion treatment is overseen during that visit. Thereafter, the frequency of nursing visits depends upon the particular therapy the patient is receiving, as well as, the level of independence the patient or carepartner has achieved with regard to the administration and monitoring of the prescribed therapy. During these subsequent visits, the nurse performs an assessment of the patient's intravenous lines and related equipment, obtains blood samples, changes the pump settings and/or drug administration, assesses the patient's condition and compliance with the plan of care and provides ongoing teaching and support. The patient's supplies and drugs are typically delivered on a weekly basis depending on the therapy and the type of drugs being administered. The treating physician and the payer case manager remain actively involved in the patient's treatment by monitoring the success of the plan of treatment and revising it as necessary.

ALTERNATE SITE INFUSION THERAPY: PRODUCTS AND SERVICES

General. Coram provides a variety of infusion therapies, principally nutrition, anti-infective therapies, pain management and IVIG, as well as, coagulant and blood clotting therapies for patients with hemophilia. A physician, based-upon a patient's diagnosis, treatment plan and response to therapy, determines the initiation and duration of these therapies. Certain therapies, such as anti-infective therapies, are generally used in the treatment of temporary infectious conditions, while others, such as nutrition, IVIG and blood coagulants, may be required on a long-term or permanent basis. The patient, the designated carepartner or an employee of Coram administers infusion therapies at the patient's home. In some patient groups, such as immuno-suppressed patients (e.g., AIDS/HIV, cancer, transplant patients, etc.), blood coagulant therapies or anti-infective therapies may be provided periodically over the duration of the primary disease or for the remainder of

the patient's life, generally as episodic care.

Nutrition Therapy. Total parenteral nutrition therapy ("TPN") involves the intravenous feeding of life-sustaining nutrients to patients with impaired or altered digestive tracts due to inflammatory bowel disease, short bowel syndrome, pancreatitis or other gastrointestinal illnesses. The therapy is generally administered through a central catheter surgically implanted into a major blood vessel to introduce the nutrient solution into the bloodstream. The nutrient solution may contain amino acids, dextrose, fatty acids, electrolytes, trace elements, minerals and/or vitamins. In many cases, the underlying illness or condition from which parenteral nutrition patients suffer is recurrent in nature requiring periodic re-hospitalization for treatment followed by resumption of parenteral nutrition at home. Some patients must remain on TPN for life and other patients may require short-term TPN therapy to augment their nutritional status, such as patients with a diagnosis of cancer, hyperemesis, AIDS/HIV and eating disorders.

Enteral nutrition therapy is administered through a feeding tube into the gastrointestinal tract of patients who cannot eat as a result of an obstruction to the upper gastrointestinal tract or other medical conditions. Enteral nutrition therapy is frequently administered over a long period, often for six months or longer.

Anti-Infective Therapy. Anti-infective therapy is the infusion of antibacterial, anti-viral or anti-fungal medications into the patient's bloodstream for the treatment of a variety of infectious episodes, such as osteomyelitis (bone infections), bacterial endocarditis (infection of the heart valves), wound infections, infections associated with AIDS/HIV, cancer, post-kidney transplant treatment protocols and infections of the kidneys and urinary tract. Intravenous anti-infective drugs are delivered through a peripheral catheter inserted in a vein in the patient's arm or via a centrally placed catheter. Anti-infective drugs are often more effective when infused directly into the bloodstream rather than taken orally.

Pain Management. Pain management services encompass the treatment of pain and the management of related symptoms, resulting from either malignant or non-malignant diseases. Unrelieved pain and related symptoms are major contributors to emergency room visitations, as well as, readmissions and extended stays in hospitals. Pain management drugs are typically delivered by intravenous, subcutaneous or intraspinal (e.g., epidural) therapy, often in connection with the delivery of other core therapies.

Intravenous Immunoglobulin. IVIG therapy involves the administration of blood derivative products (gammaglobulins), which are administered to patients with an immune deficiency or an altered immune status. IVIG therapy is most commonly administered to patients with primary immune deficiencies or autoimmune disorders. Patients receiving IVIG therapy for primary immune deficiencies usually receive the therapy for life. Depending on the severity of their condition, patients receiving IVIG therapy for autoimmune disorders are treated intermittently over a period of months. IVIG products are delivered through a peripheral catheter inserted in a vein in the patient's arm or via a centrally placed catheter over one to five days, depending on the type of disorder being treated.

Coagulant and Blood Clotting Therapies. Coagulation or factor replacement therapy is the intermittent administration of a blood clotting factor. Blood clotting factors are generally administered to persons with hemophilia or related genetic disorders which affect the blood's ability to clot. In these disorders, one or more of the normal blood clotting factors is not produced in sufficient amounts by

the body. The absence of these clotting factors makes it difficult or impossible for a patient to stop bleeding. Severe hemophiliacs can suffer from spontaneous bleeding episodes without trauma. Repeated bleeding episodes can cause permanent loss of mobility in the joints, thereby placing the patient at further risk medically and impacting their ability to live a normal life. Factor replacement products are administered via a centrally inserted or peripherally inserted intravenous catheter over a short period of time (approximately 10 minutes). Factor is infused when bleeding episodes occur or on a routine preventative basis (prophylaxis). Most patients (even children) and/or their carepartners learn to start their own intravenous catheter and administer their blood clotting factor products. Persons with hemophilia and others who have inherited clotting disorders will require these products throughout their lives.

Availability of factor product from manufacturers can be inconsistent and is dependent on many variables, including manufacturing capacity, manufacturer regulatory compliance, donor pools, production lots, contamination, etc. If a shortage occurs, Coram may be required to purchase through the secondary or distributor market, wherein pricing may not be favorable and product availability can change significantly from day to day. During such times of shortages, prices increase dramatically with limited availability to pass these additional costs on to patients and payers. Moreover, product shortages may make it difficult for Coram to meet the needs of its patients (a single patient's requirements may, at any given time, expend what would otherwise be adequate inventory for multiple patients) and may have an adverse impact on Coram's future results of operations. The current domestic supply of factor products is meeting or exceeding demand and Coram is able to acquire adequate amounts of these products in order to meet its current and anticipated short-term patient demand. Additionally, management is taking further proactive steps to ensure a ready supply of factor products for current and future patients. However, product shortages will continue to occur due to the nature of the manufacturing and regulatory environment of these products and any disruption to the company's factor product supply chain could have a materially adverse impact on future operating results.

Transplant Services. Coram developed a distinct transplant program and is providing therapies and services to pre-and post bone marrow, blood cell and organ transplant patients. This clinically focused care management program includes, among other things, proprietary patient and environmental assessment and monitoring protocols, patient education tools and clinical training programs. The most common therapy for transplant patients is anti-infective therapy, including antibiotics, anti-viral and anti-fungal agents, most often prescribed intravenously to prevent or treat an infection due to the patient's immuno-compromised status. Other prescribed therapies include TPN, IVIG, biologic response modifiers, immunosuppressive therapies and blood products.

Respiratory Therapy Services and Related Equipment and Durable Medical Equipment. Certain Coram and affiliated partnership branches provide respiratory therapy services and related equipment to patients for use in their homes. In addition, such branches also provide durable medical equipment in a patient's home setting, which complements the company's core home infusion and respiratory therapy services businesses. Whether administered separately to chronically ill pulmonary patients or in conjunction with Coram's other services, dedicated respiratory and other professionals are committed to positive patient outcomes, referral source communication, physician satisfaction and high standards of clinical excellence. Coram's integrated service approach allows patients to access infusion, respiratory and other therapy services, as well as durable

medical equipment, through a single healthcare provider.

Other Non-Core Therapies. Coram provides other technologically advanced therapies such as antineoplastic chemotherapy, intravenous inotropic therapy for patients with congestive heart failure or for those who are awaiting cardiac transplants, intravenous anti-coagulant therapy for the prevention of blood clots, and anti-nausea therapy for chemotherapy induced emesis or hyperemesis gravidarum. Hydration therapy is often administered in conjunction with intravenous chemotherapy. Other non-core therapies, as described herein, are not generally material to the company's results of operations.

ALTERNATE SITE INFUSION THERAPY: ORGANIZATION AND OPERATIONS

General. Coram's alternate site infusion therapy business operations are currently conducted through 77 branches. At December 31, 2001, the branches were divided into two geographic areas, each having a Senior Vice President of Operations. During the year ended December 31, 2002, the company further divided its operations into three geographical areas, each having a Senior Vice President of Operations or a Vice President of Operations (collectively the "Senior Vice Presidents of Operations") reporting directly to the President and an Area Vice President of Sales reporting directly to the Senior Vice President of Sales. The aforementioned changes during 2002 fostered a greater level of interactive collaboration between the Area Vice Presidents of Sales and the company's sales force and allowed the Senior Vice Presidents of Operations to focus on their areas in a more comprehensive manner. Moreover, this organizational structure was designed to create operating and decision-making efficiencies. Management believes that the functional approach to management facilitates high quality local decision-making, which allows Coram to attract and retain experienced local managers and be responsive to local market needs. Management continuously reviews operations, focusing on cost effective delivery of quality patient care. For example, Coram established a Hemophilia Services Division and specialty hemophilia distribution centers in Malvern, Pennsylvania,

Albuquerque, New Mexico and Sacramento, California. Each center utilizes existing Coram branch resources and concentrates experienced clinicians and management on the unique needs of hemophilia patients and their carepartners.

Operating Systems and Controls. An important factor in Coram's ability to monitor its operating locations is its management information systems. Besides routine financial reporting, the company has developed a performance model for monitoring the field operations of its infusion business. Actual operating results derived from the management information systems can be compared to the performance model, enabling management to identify opportunities for increased efficiency and productivity. Management believes that the use of standardized, specific performance matrices and the identification and monitoring of best demonstrated practices facilitate operational improvements.

Coram endeavors to ensure that its local managers have the appropriate authority and ability to perform effectively by providing training, education, policies and procedures and standardized systems. Coram maintains various management incentive plans that reward performance based on revenue growth, accounts receivable collection, inventory control and contribution of earnings before interest expense, income taxes, depreciation and amortization ("EBITDA").

ALTERNATE SITE INFUSION THERAPY: QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT

Coram maintains accreditation for its infusion therapy business that is

consistent with its service standards and enables the company to monitor whether the objectives of those standards are met. The company successfully completed its triennial survey of all locations with the Joint Commission on the Accreditation of Health Care Organizations in 2001. In anticipation of the beginning of a new triennial period and as a normal course of business, Coram evaluated its options for accreditation by a nationally recognized independent organization. In connection therewith, Coram elected to pursue recurring national accreditation from the Accreditation Commission on Health Care, Inc. ("ACHC"). To prevent a lapse in accreditation, Coram underwent its corporate survey with ACHC in December 2001 and received Accreditation with Commendation, which applies to all services provided at all locations effective January 1, 2002. ACHC will conduct ongoing surveys at Coram locations to monitor continued compliance with ACHC standards throughout the three year accreditation period. During the year ended 2002, thirty six locations participated in the ACHC survey process and all such locations received accreditation.

An integral part of Coram's commitment to clinical excellence is the national and branch specific Performance Improvement programs, which are fully integrated into the daily business model. The Performance Improvement programs serve to:

(i) evaluate branch programs, policies and procedures and amend protocols as needed;

(ii) provide ongoing direction to performance improvement efforts;

(iii) measure patient and customer satisfaction and analyze trends, responding as necessary to achieve better customer service;

(iv) monitor clinical outcome measures, including access device related outcomes and rehospitalizations, analyze trends and act as necessary to improve customer outcomes;

(v) assist in the development of new programs or procedures to meet recognized needs within the branch or the community that it serves;

(vi) evaluate the branch staff efforts related to professional and clinical issues such as clinical monitoring of patients; and

(vii) identify, monitor and modify key performance areas of operations.

Further, Coram's Clinical Operations Department assists branch management in assessing the levels of service being provided to patients. Coram's integrated approach to performance improvement is designed to identify national, area, regional and branch specific trends related to high volume, high risk, problematic and new activities. It encompasses continuous assessment and measurement of patient and customer satisfaction at both local and national levels, as well as, the comprehensive tracking, measuring and monitoring of important clinical outcomes. It also encompasses the measurement of management's success in achieving the desired operational and fiscal benchmarks that are key to the company's success.

RESPIRATORY THERAPY SERVICES AND RELATED EQUIPMENT AND DURABLE MEDICAL EQUIPMENT

Coram provides a full line of respiratory therapy services and equipment, including, but not limited to, respiratory medications, oxygen systems, home ventilators, sleep apnea equipment, nebulizers, Continuous Positive Airway

Pressure ("CPAP") systems and Bilevel Positive Airway Pressure ("BiPAP") systems. In addition, Coram provides other durable medical equipment, such as hospital beds, wheelchairs and walkers, to serve the needs of its patients. Both respiratory and durable medical equipment are available to patients for purchase or rent. There are many synergies between these product lines and the company's base infusion business that benefit both the company and its customers. Coram primarily benefits from the opportunity to provide respiratory therapy services and equipment and durable medical equipment to patients who are already receiving infusion or other services. Additionally, patients and payers benefit from the opportunity to obtain comprehensive healthcare services and equipment through a single source.

The aforementioned services are provided through branches located in San Diego, California; Indianapolis, Indiana; Lenexa, Kansas; and Detroit, Michigan. Coram also provides these services through one of its partnerships with three locations in Wisconsin. In 2002, Coram completed the sale of its respiratory and durable medical equipment business located in New Orleans, Louisiana (see Notes 3 and 5 to the company's Consolidated Financial Statements for further details) and closed its Casper, Wyoming facility.

CLINICAL RESEARCH

Coram has been providing support services for clinical research studies since 1995. In 1998, the company created a Clinical Research division and began devoting additional resources to, and actively marketing, its capabilities in this area. This division is operated through the company's wholly-owned subsidiary, CTI Network, Inc. ("CTI"). Utilizing integrated information systems and Coram's national network of approximately 700 full-time equivalent alternate site infusion nurses and pharmacists, as well as, contracted nurses from non-Coram agencies, CTI offers its customers the opportunity to effectively and efficiently complete some of the most challenging aspects of a clinical trial by:

(i) providing alternate site healthcare services such as therapy administration, specimen collection, patient education and training, patient assessments and data collection;

(ii) providing alternate site pharmacy services;

(iii) providing patient screening and surveying services;

(iv) providing product acquisition of comparative medications;

(v) providing single source contracting through a central office for national services;

(vi) providing nurse study coordinators at the physician's office; and

(vii) assisting in the identification of potential investigators.

SOLUNET LLC ("SOLUNET"): OUTSOURCED HOSPITAL COMPOUNDING SERVICES

In November 2002, the company organized SoluNet as a wholly-owned subsidiary for the purpose of providing sterile product compounding services to hospitals. SoluNet's product offerings include patient-specific TPN, dialysis and cardioplegia solutions, which are compounded and dispensed by select Coram branch pharmacies under highly controlled conditions that are consistent with guidelines established by the American Society of Health-System Pharmacists. Each bag of compounded solution is individually labeled based on customer specifications and delivered to the hospital on a daily basis. Outsourcing to SoluNet promotes hospital pharmaceutical care models and facilitates the reallocation of critical hospital resources to internal initiatives, thereby

promoting improved quality of patient care, achievement of cost savings and other strategic and tactical goals. SoluNet works closely with hospital stakeholders during all phases of program implementation and execution in order to design programs that meet each hospital's unique clinical, operational and fiscal requirements while allowing the hospitals to maintain important relationships with their drug and supply vendors.

CPS: PHARMACY BENEFIT MANAGEMENT AND SPECIALTY MAIL-ORDER PHARMACY SERVICES

On July 31, 2000, the company completed the sale of CPS to Curascript Pharmacy Services, Inc. and Curascript PBM Services, Inc. (collectively the "Buyers"). The Buyers were newly formed affiliates of GTCR Golder Rauner, L.L.C. and were led by certain members of the former CPS management team. See Note 5 to the company's Consolidated Financial Statements for further details.

CPS offered HMO, PPO, at-risk physician groups, self funded employer benefit plans, labor organizations and other managed care customers pharmacy benefit management and specialty mail-order pharmacy services. The pharmacy benefit management services included on-line claims administration, formulary management and drug utilization review and were provided through a nationwide network of over 51,000 retail pharmacies. The company generally maintained approximately 60 such arrangements in place for pharmacy benefit management services. CPS's specialty mail-order pharmacy service included centralized distribution, compliance monitoring, patient education and clinical support to patients with specialized needs. In particular, CPS focused its marketing efforts on patients with organ transplants, HIV/AIDS, growth deficiencies and other chronic conditions. As of July 31, 2000, CPS had approximately 6,200 active patients receiving its specialty mail-order pharmacy services.

REIMBURSEMENT OF SERVICES

Virtually all of Coram's operating revenue is derived from third-party payers, including private insurers, managed care organizations such as HMOs and PPOs, at-risk physician groups and governmental payers such as Medicare and Medicaid. Similar to other healthcare service providers, Coram experiences prolonged reimbursement payment cycles in certain circumstances as a result of third-party payment procedures. Consequently, management of accounts receivable through effective patient registration, qualification, billing, documentation and collection procedures is critical to financial success and continues to be a high priority for management. Coram continues to focus on the appropriate processing of claims and the careful screening of new patients to determine that adequate reimbursement will be available and will be received in a timely manner.

In certain instances, fixed fee or capitated fee arrangements are utilized. Under a capitated fee arrangement, Coram would agree to deliver or arrange for the delivery of certain home health services required under the payer customer's health plan in exchange for a fixed per member per month service fee. The total per member per month fee is calculated using all members enrolled in the particular health plan as of certain specified dates. Before establishing the appropriate per member per month fee, Coram typically reviews utilization data provided by the payer customer and/or other available utilization data. In some instances, the per member per month rates will be adjusted or reconciled periodically to reflect actual utilization to prevent excess losses by the company or excess expenditures by the payer customer. As of December 31, 2002, Coram was a party to only three capitated arrangements (one of which converted to a fee-for-service arrangement effective January 1, 2003). Capitated contracts

represented approximately 8.0%, 6.3% and 4.0% of the company's consolidated net revenue for the years ended December 31, 2002, 2001 and 2000, respectively. Approximately 6.6%, 5.5% and 3.4% of the company's consolidated net revenue for the years ended December 31, 2002, 2001 and 2000, respectively, related to a capitated agreement that provides services to members in the California marketplace. See Note 2 to the company's Consolidated Financial Statements for further details.

Reimbursement amounts are collected from various sources, such as insurance companies, self-insured employers, patients and the Medicare and Medicaid programs. The Centers for Medicare & Medicaid Services ("CMS") has developed, for use in the Medicare Part B program, a national fee schedule for respiratory therapy, home medical equipment and infusion therapy, which provides reimbursement at 80% of the amount of any fee on the designated fee schedule. The remaining 20% co-insurance portion is the obligation of secondary insurance and/or the patient. A substantial amount of the revenue Coram earns under the Medicare program originates from the Part B program. Private indemnity payers typically reimburse at a higher amount for a given service and provide a broader range of benefits than governmental and managed care payers, although net revenue and gross profit from both private and other third-party non-governmental payers have been affected by continuing efforts to contain or reduce reimbursement for healthcare services. In recent years, an increasing percentage of Coram's net revenue has been derived from agreements with HMOs, PPOs, managed care providers and other contracted payers. Although these agreements often provide for negotiated reimbursement at reduced rates, they generally result in lower bad debts and provide opportunities to capture a greater volume of business as compared to traditional indemnity referrals.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation and revision. Management acknowledges and is complying with certain ongoing audits and reviews with respect to prior reimbursements from Medicare and Medicaid. While management believes that the company is in substantial compliance with all applicable laws and regulations, compliance with such laws and regulations can be subject to future government review and interpretation, as well as, significant regulatory action, including fines, penalties and exclusion from the Medicare and Medicaid programs. To minimize the

potential exposure to the company and to more readily comply with the applicable federal and state regulations, Coram established a national compliance committee to regularly review audit activity and to identify and correct compliance issues. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further details.

For most of the drugs that Coram provides to its patients, it is reimbursed by governmental and third party payers according to rate schedules that are based on the Average Wholesale Price ("AWP") of the drugs as published by commercial pricing services. For example, the Medicare program's allowable payment amount is generally 95% of the published AWP of a drug. AWP is an industry term that is typically understood to represent a suggested price for wholesale sales to pharmacies. AWP does not necessarily reflect the price paid by either pharmacies or other end user purchasers. There can be no assurances that government or private healthcare programs will continue to reimburse for drugs and biologicals based on the current AWP-based methodologies, or that future AWPs, revised AWPs or other payment methods will reflect acquisition prices available to purchasers such as the company. If government or private health insurance programs discontinue or modify the use of AWP or otherwise

implement payment methods that reduce the reimbursement for drugs and biologicals, the company's profit margins may be reduced and, in many cases, be inadequate when combined with the costs of clinical services and overhead expenses associated with the delivery and administration of the drugs and biologicals. These circumstances could produce a material adverse impact on the company's overall profit margins. See "Government Regulations" for further details.

Management throughout the company is continuing to concentrate on enhancing timely reimbursement by emphasizing improved billing and cash collection methods, continued assessment of reimbursement systems support and concentration of the company's expertise and managerial resources into certain reimbursement locations. In December 2000, Coram announced that as part of its continuing efforts to improve efficiency and overall performance, several Patient Financial Service Centers (reimbursement sites) were being consolidated and the related reimbursement positions were being eliminated. By consolidating to fewer sites, management expects to implement improved training, more easily standardize "best demonstrated practices," enhance specialization related to payers such as Medicare and achieve more consistent and timely cash collections. Management believes that, in the long-term, payers and patients will receive better, more consistent service. However, no assurances can be given that the consolidation of the company's Patient Financial Service Centers and other related activities initiated by management will be successful in enhancing timely reimbursement or that the company will not experience a significant shortfall in cash collections, deterioration in days sales outstanding ("DSO") and/or unfavorable aging trends in its accounts receivable. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further details.

COMPETITION

The alternate site infusion therapy market is highly competitive. Some of Coram's current and potential competitors in these lines of business include:

(i) integrated providers of alternate site healthcare services;

(ii) hospitals;

(iii) local providers of multiple products and services for the alternate site healthcare market; and

(iv) physicians and physician-owned organizations, such as independent practice associations and multi-specialty group practices.

Coram has experienced increased competition in its alternate site infusion therapy business from hospitals and physicians that have sought to increase the scope of services offered through their facilities, including services similar to those offered by Coram.

During 2002, one of the company's major national competitors was sold to a company that provides specialized contract pharmacy and related services to patients with chronic diseases. Subsequent to such sale, the acquiring company discontinued services to patients receiving certain therapies, some of which are considered to be Coram's core therapies. This change in business strategy by one of the company's national competitors and business failures of certain other regional and national competitors has had a favorable impact on the company's sales and results of operations during 2002.

Coram competes with other providers on a number of critical differentiating factors, including quality of care and service, reputation within the medical and payer communities, geographic scope and price. Competition within the alternate site infusion business has been affected by the decision of

third-party payers and their case managers to be more active in monitoring and directing

the care delivered to their beneficiaries. Accordingly, relationships with such payers and their case managers and inclusion within preferred provider and other networks of approved or accredited providers is often a prerequisite to Coram's ability to continue to serve many of its patients. Similarly, Coram's ability to align itself with other healthcare service providers may increase in importance as managed care providers and provider networks seek out providers who offer a broad range of services that may exceed the range of services currently offered directly by Coram.

There are relatively few barriers to entry in the local markets which Coram serves. Local or regional providers are currently competing in many of the healthcare markets served by the company, and others may do so in the future. Entrance into the local markets by competitors could cause a decline in net revenue, loss of market acceptance of Coram's services and price competition. Coram expects to continue to encounter competition in the future that could limit its ability to maintain or increase its market share. Such competition could have an adverse effect on the business, financial condition and results of operations of Coram. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further details.

SALES AND MARKETING

Coram's alternate site infusion therapy products and services, including respiratory services and equipment and durable medical equipment, are marketed through branch sales personnel, including managed care consultants, account managers and clinical service liaisons with sales specialists focused on select Nutrition and Blood Product Programs. The company established product managers for five of its core therapies: nutrition, anti-infectives, IVIG, hemophilia-related services and pain management services through Strategic Business Units: Nutrition Services, Anti-Infectives, Blood Products Services (including hemophilia and IVIG) and Pain Management. The vice president or director for each unit has responsibility for ongoing program development and provides clinical and marketing resources to focus on growing sales in these areas.

Substantially all of Coram's new patients are referred by physicians, medical groups, hospital discharge planners, case managers employed by HMOs, PPOs or other managed care organizations, insurance companies and home care agencies. Coram's sales force is responsible for establishing, maintaining and growing referral sources. Sales employees generally receive a base salary plus incentive compensation based on core therapy patient growth, revenue growth and/or EBITDA enhancements.

Coram's network of field representatives enables it to market its services to a variety of patient referral sources, including physicians, hospital discharge planners, hospital personnel, HMOs, PPOs and insurance companies. Marketing is focused on presenting Coram's clinical expertise tailored to specific customer/patient interests, with an emphasis on certain key therapies. Specialty marketing and sales support personnel promote products and services that are outside of the base infusion therapies.

As a result of escalating pressures to contain healthcare costs,

third-party payers are participating in certain decisions regarding healthcare alternatives, using their significant bargaining power to secure discounts and to direct referrals of their enrollees to specified providers. In response thereto, Coram has directed its sales and business development strategies toward aggressively pursuing agreements with third-party payers, managed care organizations and provider networks that offer high quality, cost-effective care. Coram maintains a dedicated sales force in each of its Strategic Business Units to enhance its efforts to market and sell its services to managed care payers. The company's managed care sales representatives are deployed with a field sales force to focus on regional and national payers to effect "pull-through" from referral sources within each payer's network. Coram is currently focusing its efforts on increasing referrals through select managed care agreements, with the goal of being the preferred infusion provider, as well as, selling specialty services for nutrition, anti-infectives, IVIG and pain management therapies, services for persons with hemophilia and for persons receiving certain types of organ and bone marrow/blood cell transplants.

Sales and marketing activities for CTI are directed at the top fifty pharmaceutical and biotech companies conducting clinical research studies related to biologics, intravenous injectables, devices and oral and enteral medications within the United States. CTI's Vice President, Director of Business Development and Director of Clinical Research are responsible for coordinating sales and marketing activities such as industry presentations, exhibits at clinical research conventions and distribution of direct mail information. Marketing efforts focus on the presentation of CTI's clinical research in multiple therapeutic areas and CTI's dedicated staff. In addition, satisfaction surveys with existing clients have proven to be an important tool for CTI and such surveys have contributed to several new study awards from pharmaceutical/biotech companies. Furthermore, during 2002 CTI began advertising in a clinical research publication.

Referrals to CTI are received from directors of clinical research, project managers and clinical research associates from clinical research divisions of major pharmaceutical and biotech companies, as well as, clinical research organizations that are responsible

for study oversight, enrollment, retention and, at times, project management. The CTI Director of Business Development is responsible for establishing, maintaining and enhancing referral sources. Requests for in-home clinical research visits at the local Coram branch level are investigated by CTI professionals to assess the possibility of expanding the studies to a national level. CTI is currently focusing on increasing its business through the creation of master service agreements with volume pricing discounts to study sponsors. CTI's overall objective is to be a pharmaceutical/biotech company's preferred in-house clinical research provider.

SoluNet's services are marketed through its Business Development Managers who are responsible for established national sales territories. Using public healthcare information sources, such as the American Hospital Association, and proprietary data collected from the company's network of infusion branches, SoluNet targets specific markets for business development based upon the presence of large hospitals and hospital systems, which represent the best potential sources of new business. Additionally, SoluNet participates in and demonstrates its capabilities at selected trade shows, including the American Society of Health System Pharmacist's Midyear Clinical Meeting.

CUSTOMERS AND SUPPLIERS

Coram provides alternate site home healthcare services and products to a large number of patients and related payers. Medicare and Medicaid collectively represented approximately 25% of consolidated net revenue for the year ended December 31, 2002. No other payer accounted for more than 5% of Coram's net revenue during 2002, except for one payer with a capitated contract in the California marketplace.

The aforementioned capitated contract in the California marketplace represented approximately 6.6% of the company's consolidated revenue during the year ended December 31, 2002. Additionally, Coram owns 50% of a partnership located in California that derived approximately 41.8% of its net revenue during 2002 from services provided under such capitated agreement. Risk under this capitated arrangement is somewhat mitigated by the inclusion of contractual stop-loss provisions that protect the company and its partnership when member utilization for identified therapies exceeds contractual thresholds. Once stop-loss provisions are met in any given month, the services are reimbursed at agreed-upon fee-for-service rates. The underlying two year agreement expired by its terms on December 31, 2002 but it is subject to automatic annual renewals absent a written termination notice from one of the contracting parties. The company and its partnership continue to render services subject to the automatic renewal provisions of the contract. On February 28, 2003, the contracted payer invited Coram, as well as a limited group of other providers, to respond to a request for proposal ("RFP") that covers the services provided exclusively by Coram. Management believes that the payer will select a provider or providers in July 2003 and the new contract or contracts will become effective January 1, 2004. Management can provide no assurances that the company will successfully procure such contract on economic and operational terms that are favorable to the company. The loss of this capitated contract or significant modifications to the terms and conditions of the existing contract could have a materially adverse impact on the results of operations, cash flows and financial condition of the company and its partnership. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further details.

Coram purchases products from a large number of suppliers and considers its relationships with its vendors to be good, subject to credit uncertainty and the ongoing bankruptcy proceedings. Except for certain blood products discussed in Item 1. "Business, Alternate Site Infusion Therapy: Products and Services-Coagulant and Blood Clotting Therapies," management believes that substantially all of its products are available from alternative sources; however, see Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further discussion. Management's understanding of alternate vendor sources includes products currently being purchased through Cardinal Health, Inc., FFF Enterprises, Inc. and Baxter Healthcare Corporation, three of Coram's major suppliers of drugs and supplies. During the year ended December 31, 2002, Coram purchased drugs and supplies aggregating approximately $61.2 million from Cardinal Health, Inc., $43.9 million from FFF Enterprises, Inc. and $27.5 million from Baxter Healthcare Corporation, or approximately 34%, 24% and 15%, respectively, of its total drugs and supplies.

The principal supplier of Coram's infusion pumps, Sabratek Corporation ("Sabratek"), filed for protection under Chapter 11 of the Bankruptcy Code on December 17, 1999. In January 2000, Baxter Healthcare Corporation ("Baxter") purchased certain Sabratek assets, including Sabratek's pump manufacturing division, and continued to produce the related tubing and infusion sets needed to operate the Sabratek pole-mounted 3030 Pumps (the "3030 Pumps") and the Sabratek 6060 Homerun Pumps (the "6060 Pumps") that are used by Coram. Baxter previously discontinued production of the 3030 Pumps and, in March 2003, manufacturing of the related tubing and infusion sets necessary for repairs and

operation of such pumps was also terminated, thereby substantially exhausting the company's inventory of such required supplies. In response to this inventory shortage, management has taken certain steps to ensure that patient care will not be disrupted while the company transitions to alternate tubing and infusion set sources. As a result of the company's longstanding evaluation of several pole-mounted infusion pump alternatives, including local branch comparative clinical

and operational testing, management concluded that the company should replace its entire fleet of 3030 Pumps. In connection therewith, Coram entered into two separate agreements with B. Braun Medical, Inc. ("B. Braun") in 2003 to purchase 1,000 Vista Basic pole-mounted pumps at an aggregate cost of approximately $1.5 million. Additionally, the Chapter 11 trustee filed a motion in the Bankruptcy Court seeking approval for the company to lease an additional 1,000 Vista Basic pumps from B. Braun for an aggregate three year commitment, including related interest, of approximately $1.5 million. The Bankruptcy Court is scheduled to hear the aforementioned motion on May 1, 2003. Management is taking other actions, including, but not limited to, comprehensive employee training, to ensure a smooth transition from the 3030 Pumps to the Vista Basic pumps. However, no assurances can be provided that patient care will not be disrupted due to the pole-mounted infusion pump transition or the company's ongoing shortage of 3030 Pump tubing and infusion sets during the transition period.

Management expects that Baxter will extend the period during which it will produce the tubing and infusion sets necessary for operation of the 6060 Pumps; however, no assurances can be given that Baxter will make such an extension. Moreover, the company's fleet of 6060 Pumps requires certain costly software and hardware upgrades and the 6060 Pumps are currently experiencing significant and recurring repairs that are not covered under warranty. Such upgrades and extensive ongoing repairs will require a substantial cash outlay by the company and would temporarily remove numerous company-owned pumps from revenue-producing activities (thereby requiring the company to lease incremental pumps on a month-to-month basis). Given the issues surrounding the 6060 pumps, management is currently evaluating several alternatives, including replacement of the entire 5,500 unit fleet. No assurances can be given that the company will develop an alternative that will be economically viable, including identification of a source of long-term financing, or meet with the approval of the Chapter 11 trustee and the Bankruptcy Court.

GOVERNMENT REGULATION

General. The federal government and all states in which Coram is currently operating regulate various aspects of Coram's business. In particular, Coram's operations are subject to extensive federal and state laws regulating, among other things, the provision of pharmacy, home care, nursing services, ancillary network management services, health planning, health and safety, environmental compliance and toxic and medical waste disposal. Coram is also subject to fraud and abuse and self-referral laws, which affect its business relationships with physicians, other healthcare providers and referral sources and its reimbursement from government payers. Generally, all states require infusion companies to be licensed as pharmacies and to have appropriate state and federal registrations for dispensing controlled substances. Some states require infusion companies to be licensed as nursing or home health agencies and to obtain medical waste permits. In addition, certain company employees are subject to state laws and regulations governing the ethics and professional practices of pharmacy and/or nursing.

Coram may also be required to obtain certifications or register in order to participate in governmental payment programs such as Medicare and Medicaid. Some states have established certificate-of-need programs regulating the establishment or expansion of healthcare operations, including certain of Coram's operations. The failure to obtain, renew or maintain any of the required regulatory approvals, certifications, registrations or licenses could adversely affect Coram's business and could prevent the location or locations involved from offering products and services to patients and/or from billing third-party payers. Coram's operating results could be adversely affected, directly or indirectly, as a result of any such actions. Management believes that Coram complies, in all material respects, with these and all other applicable laws and regulations. The healthcare services industry will continue to be subject to pervasive regulation at the federal and state levels, the scope and effect of which cannot be predicted. No assurances can be given that the activities of Coram will not be reviewed and challenged or that government sponsored healthcare reform, if enacted, will not result in material adverse changes to the company.

Fraud and Abuse. Coram's operations are subject to the illegal remuneration provisions of the Social Security Act (sometimes referred to as the "anti-kickback" statute) that imposes criminal and civil sanctions on persons who knowingly and willfully solicit, offer, receive or pay any remuneration, whether directly or indirectly, in return for, or to induce, the referral of a patient for treatment, or, among other things, the ordering, purchasing or leasing, of items or services that are paid for in whole or in part by federal healthcare programs. Violations of the federal anti-kickback statute are punishable by criminal penalties, including imprisonment, fines and exclusion of the provider from future participation in federal healthcare programs. Federal healthcare programs have been defined to include any plan or program that provides health benefits funded by the United States Government and commonly include, among others, Medicare, Medicaid and the Civilian Health and Medical Program of the Uniformed Services. Administrative exclusion and civil monetary penalties for anti-kickback violations can also be imposed through an administrative process. Federal enforcement officials may also attempt to use other general federal statutes to punish behavior considered fraudulent or abusive, including the Federal False Claims Act, which provides for penalties of up to $11,000 per claim plus treble damages, and permits private persons to sue on behalf of the government. While the federal anti-kickback statute expressly prohibits transactions that have traditionally had criminal implications, such as kickbacks, rebates or bribes for patient referrals, its language has been construed broadly and has not

been exclusively limited to such obviously wrongful transactions. Some court decisions state that, under certain circumstances, the statute is also violated when "one" purpose (as opposed to the "primary" or a "material" purpose) of a payment is to induce referrals. Congress has frequently considered, but has not yet adopted, federal legislation that would expand the federal anti-kickback statute to include the same broad prohibitions regardless of payer source.

In addition to the payment or receipt of illegal remuneration for the referral or generation of federal healthcare program business, the fraud and abuse laws cover other billing practices that are considered fraudulent (such as presentation of duplicate claims, claims for services not actually rendered or for procedures that are more costly than those actually rendered) or abusive (such as claims presented for services not medically necessary based upon a

misrepresentation of fact) and are subject to the same remedies as described above.

Similarly, a large number of states have varying laws prohibiting certain direct or indirect remuneration amongst healthcare providers for the referral of patients to a particular provider, including pharmacies and home health agencies. Possible sanctions for violations of these laws include loss of licensure, exclusion from state funded programs and civil and criminal penalties.

Although management believes that the company is in compliance with the various federal and state fraud and abuse statutes, failure to comply with such laws and regulations could have a material adverse effect on the company.

Prohibition on Physician Referrals. Under the Omnibus Budget Reconciliation Act of 1993 (commonly referred to as "Stark II"), it is unlawful for a physician to refer patients for certain designated health services reimbursable under the Medicare or Medicaid programs to an entity with which the physician and/or the physician's family, as defined under Stark II, has a financial relationship, unless the financial relationship fits within an exception enumerated in Stark II or regulations promulgated thereunder. Aspects of Coram's business which are "designated health services" for purposes of Stark II include outpatient prescription drugs, parenteral and enteral nutrition, equipment and supplies, durable medical equipment and home health services. A "financial relationship" under Stark II is defined broadly as an ownership or investment interest in, or any type of compensation arrangement in which remuneration flows between the physician and the provider. Coram has financial relationships with physicians and physician owned entities in the form of medical director agreements and service agreements pursuant to which the company provides pharmacy products. In each case, the relationship has been structured, based on advice of legal counsel, using an arrangement management believes to be consistent with applicable exceptions set forth in Stark II, such as the personal services arrangements exception or the exception for payments by a physician for items and services.

In addition, the company is aware of certain referring physicians (or their immediate family members) that have had financial interests in the company through ownership of shares of the company's common stock. The Stark II law includes an exception for the ownership of publicly traded stock in certain companies with equity above certain levels. This exception under Stark II requires the issuing company to have stockholders' equity of at least $75 million either as of the end of its most recent fiscal year or on average over the last three fiscal years. Due principally to the extraordinary gains on troubled debt restructurings (see Note 9 to the company's Consolidated Financial Statements for further details), at December 31, 2002 the company's stockholders' equity was above the required level. However, in light of the company's recurring operational losses during each of the years in the three year period ended December 31, 2002, management's ability to maintain an appropriate level of stockholders' equity cannot be reasonably assured. The penalties for failure to comply with Stark II include, among other things, non-payment of claims and civil penalties that could be imposed upon the company and, in some instances, upon the referring physician. Some of these penalties can be imposed regardless of whether the company intended to violate the law.

Management has been advised by legal counsel that a company whose stock is publicly traded has, as a practical matter, no reliable way to implement and maintain an effective compliance plan for addressing the requirements of Stark II other than complying with the public company exception. Accordingly, if the company's common stock remains publicly traded and its stockholders' equity falls below the required levels, the company would be forced to cease accepting referrals of patients covered by Medicare or Medicaid programs or run a significant risk of noncompliance with Stark II. Because referrals of the

company's patients with such government-sponsored benefit programs comprise approximately 25% of the company's consolidated net revenue for the year ended December 31, 2002, discontinuing the acceptance of patients with government-sponsored benefit programs would have a material adverse effect on the financial condition, results of operations and cash flows of the company. Additionally, ceasing to accept such referrals could materially adversely affect the company's business reputation in the marketplace as it may cause the company to be a less attractive provider to which a physician could refer his or her patients.

Under Stark II, an entity is prohibited from claiming payment under the Medicare or Medicaid programs for services rendered pursuant to a prohibited referral and is liable for the refund of amounts received pursuant to prohibited claims. The entity can also be

assessed civil penalties of up to $15,000 per improper claim and can be excluded from participation in the Medicare and/or Medicaid programs. In addition, a number of the states in which the company operates have similar prohibitions on physician self-referrals with corresponding penalties. Although management believes it has structured its financial relationships with physicians to comply with Stark II and applicable state law equivalents, the failure to comply with the provisions of such laws could have a material adverse effect on the company.

Other Fraud and Abuse Laws. 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 Federal False Claims Act may result in civil penalties and forfeitures and exclusion from the Medicare and Medicaid programs. The Health Insurance Portability and Accountability Act of 1996 created two new federal crimes: "Healthcare Fraud" and "False Statements Relating to Healthcare Matters." The Healthcare Fraud statute prohibits knowingly and willfully executing a scheme or artifice to defraud any healthcare benefit program. A violation of this statute is a felony and may result in fines and/or imprisonment. The False Statements Relating to Healthcare Matters 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.

In recent years, the federal government has significantly increased the financial resources allocated to enforcing the healthcare fraud and abuse laws. In addition, private insurers and various state enforcement agencies have increased their level of scrutiny of healthcare claims in an effort to identify and prosecute fraudulent and abusive practices. Although management believes the company is in compliance with fraud and abuse laws, the failure to comply with any such laws could have a material adverse effect on the company.

Medicare and Healthcare Reform. As part of the Balanced Budget Act of 1997 (the "BBA"), Congress made numerous changes that affect Part A certified home health agencies and Part B suppliers like Coram that participate in the Medicare program. These policies were subsequently modified by the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (the "BBRA") and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the "BIPA").

The BBA, as modified by the BBRA, required certified home health agencies participating in Part A of the Medicare program to post surety bonds in an amount equal to the lesser of 10% of the amount that Medicare paid to the

provider in the prior year or $50,000. The deadline for securing such bonds has been extended indefinitely while CMS reviews the bonding requirements. CMS has indicated that the new compliance date will be sixty days after the publication of the final rule. Management believes that, based upon currently available information derived from discussions with surety bond brokers and organizations that issue surety bonds, the necessary bonds will not be generally available to home health providers until CMS revises its bonding requirements in a way that clarifies and/or limits the types of liabilities that will be covered by the bonds. As of April 11, 2003, the company had only one Medicare Part A certified home health provider location, which has not obtained a surety bond.

As required by the BBA, CMS also intends to issue separate surety bond regulations applicable to Medicare Part B suppliers; however, such regulations have not yet been finalized. Virtually all of Coram's branch offices participate as suppliers in the Medicare Part B program. Additionally, similar bonding requirements are being reviewed by state Medicaid programs and at least one state requires Medicaid suppliers to maintain a surety bond. If surety bond requirements become effective for the Medicare program or for additional state Medicaid programs and if Coram is not able to obtain all of the necessary surety bonds, it may have to cease its participation in the Medicare and/or Medicaid programs for some or all of its branch locations. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Liquidity and Capital Resources - Part A and Part B Medicare Surety Bonds" for further details.

The BBA also reduced reimbursement for oxygen and oxygen related therapies by 25% effective January 1, 1998 with an additional 5% reduction effective January 1, 1999 and in subsequent years. In addition, the BBA eliminated consumer price index updates for durable medical equipment and parenteral and enteral nutrients, supplies and equipment for five years, thereby "freezing" the payment amount for such items until the year 2003. The BBRA restored a portion of the durable medical equipment and oxygen payments for 2001 and 2002, and the BIPA further modified payments for durable medical equipment by providing a full inflation update for items of durable medical equipment (but not oxygen and oxygen equipment) in 2001.

The BBA also mandated the implementation of a prospective payment system ("PPS") for home health services, which went into effect on October 1, 2000. Under PPS, Medicare pays home health agencies for each covered 60-day episode of care, based on the care needs of the patients, as determined by a standardized assessment tool used to assess patient needs. Agencies are also eligible for outlier payments if the costs of caring for an individual beneficiary are significantly higher than the specified payment rate. The BIPA

delayed a scheduled 15% reduction in aggregate home health PPS amounts until October 1, 2002. The Medicare Payment Advisory Commission ("MedPAC"), a Congressional advisory panel, did not endorse repealing the 15% cut in PPS rates in its March 2003 report to Congress.

The aggregate amount of Medicare payments to home health agencies in each of the fiscal years 2002 and 2003 will equal the aggregate payments in the preceding fiscal year, updated by the market basket index ("MBI") increase, minus 1.1%. For fiscal year 2004, home health agencies are scheduled to receive a full MBI update. However, MedPAC's March 2003 report to Congress recommended that this fiscal year 2004 MBI update be eliminated because of high industry profit margins. MedPAC also recommended that Congress provide additional funding

for certain home health agencies serving beneficiaries in rural areas.

The BIPA also addressed CMS' policies regarding coverage of and payment for drugs and biologicals. For instance, the BIPA required that payment for drugs under Part B of the Medicare program be made on an assigned basis; in other words, the provider must accept the Medicare fee schedule amount as payment in full.

The BIPA further addressed CMS' attempts to modify the use of the average wholesale price ("AWP") for purposes of Medicare payment for certain drugs. In recent years, state and federal government enforcement agencies have conducted ongoing investigations of manufacturers' practices with respect to AWP in which they have suggested that "inflated" AWPs have led to excessive government payments for prescription drugs and biologicals. Several private lawsuits have also been filed against manufacturers based on similar allegations seeking recoveries on behalf of patients and private healthcare plans. As a result of these investigations, federal and state policymakers have begun to question the appropriateness of continuing to reimburse for drugs and biologicals under federal programs using AWP-based methodologies. For example, the BIPA required the General Accounting Office ("GAO") to study Medicare reimbursement for drugs and biologicals and related services. The Secretary of the Department of Health and Human Services (the "DHHS") is required to revise the current Medicare payment methodologies for covered drugs and biologicals and related services based on the GAO's recommendations. The BIPA also placed a temporary moratorium on decreases (but not increases) in Medicare reimbursement for Part B drugs until the Secretary of the DHHS reviews the GAO report.

The GAO released its AWP report in September 2001, which found that physicians are able to obtain Medicare-covered drugs at prices significantly below current Medicare payments. Likewise, the GAO found that wholesalers' and group purchasing organizations' prices, which would generally be available to physicians, were less than AWPs used to establish the Medicare payment for these drugs. In connection with these findings, the GAO recommended that CMS reimburse providers for Medicare Part B-covered drugs and related services at levels reflecting the provider's acquisition costs. CMS agreed that Medicare should appropriately pay for both Part B-covered drugs and the services required to furnish them, although CMS has not yet released a comprehensive plan to reform drug payments. However, in December 2002 CMS announced that it was establishing a new "single drug pricer" to correct differences among fiscal intermediaries in payment amounts for certain Medicare-covered drugs (but not including drugs billed to durable medical equipment regional carriers, such as home infusion drugs, and certain other drugs). Prior to adoption of this policy, individual fiscal intermediaries determined reimbursement rates for the applicable drugs based on 95% of the AWP that manufacturers submitted to reporting publications such as RedBook and First Data Bank. However, actual Medicare reimbursement for a particular drug varied from fiscal intermediary to fiscal intermediary because of different data sources used to determine AWP. The new unified rates became effective January 1, 2003. A number of legislative proposals to revise the Medicare payment methodology for drugs and biologicals has also been introduced in Congress, but they have not been enacted to date.

In addition, as part of government investigations of AWP, the Department of Justice and states' attorneys general developed "revised" AWPs for a number of drugs and biologicals that are generally lower than those published by commercial services. The Medicare program proposed that these revised AWPs be used in determining Medicare reimbursement amounts, but this proposal was withdrawn in light of the BIPA provision described above. However, according to an October 2001 report by the DHHS Office of Inspector General, approximately 30 state Medicaid programs are using the revised AWPs to establish reimbursement amounts for some of the listed drugs and biologicals in certain patient care settings. If government or private health insurance programs discontinue or modify the use of AWP or otherwise adopt payment reductions for drugs or

biologicals, it could adversely affect Coram's reimbursement for these products.

The BBA also authorized certain demonstration projects for competitive bidding through December 31, 2002. The first competitive bidding project in Polk County, Florida used payment rates that were between 13% and 31% lower than Medicare's existing fee schedule for five categories of products, including oxygen equipment and supplies, enteral nutrition equipment and supplies and urological supplies. Another round of competitive bidding began in Polk County in October 2001, covering oxygen equipment and supplies, hospital beds and accessories, urological supplies and surgical dressings. A second competitive bidding project was launched on February 1, 2001 in the San Antonio, Texas area and applied to, among other things, oxygen equipment and supplies and nebulizer inhalation drugs. Although CMS' competitive bidding demonstration projects have lapsed, President Bush and

many members of Congress have called for expanded Medicare competitive bidding authority for medical equipment, and corresponding legislation could be considered in the future to provide for such programs.

The long-range impact of the home health prospective payment system and future competitive bidding projects is unclear. Accordingly, there can be no assurances that adoption of these or other payment systems and the implementation of the Medicare reimbursement reductions and freezes described above will not result in a material decrease in the amount of reimbursement Coram receives from the Medicare program for the services it currently provides and any other home health or related oxygen, durable medical equipment or home infusion services Coram may provide in the future.

Health Information Practices. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") mandate, among other things, the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and efficiency of the healthcare industry. Among the standards that the Department of Health and Human Services (the "DHHS") must adopt pursuant to HIPAA are standards for the following: electronic transactions and code sets; unique identifiers for providers, employers, health plans and individuals; security and electronic signatures; privacy; and enforcement. Sanctions for failing to comply with the HIPAA health information practices provisions include criminal penalties and civil sanctions.

Although HIPAA was intended ultimately to reduce administrative expenses and burdens faced within the healthcare industry, the law may initially bring about significant and, in some cases, costly changes. The DHHS has released three rules to date mandating the use of new standards with respect to certain healthcare transactions and the privacy and security of personal medical information. The first rule requires the use of uniform standards for common healthcare transactions, including healthcare claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advices, plan premium payments and coordination of benefits. This rule went into effect October 16, 2002; however, covered entities could obtain a one year extension until October 16, 2003 by filing an action plan with the DHHS. In September 2002, Coram filed a Model Compliance Plan describing how the company will comply with the HIPAA standards and, in connection therewith, Coram was granted a one year extension. On February 20, 2003, the DHHS published certain modifications to the final transaction standards but these changes did not affect the compliance deadline.

The DHHS also released new standards relating to the privacy of individually identifiable healthcare information. These standards not only require compliance with rules governing the use and disclosure of protected healthcare information, but they also impose those rules, by contract, on any business associate to whom such information is disclosed. The privacy standards were issued on December 28, 2000 and became effective on April 14, 2001, with a mandatory compliance date of April 14, 2003. In August 2002, the DHHS announced final revisions to certain aspects of the privacy rule but did not change the compliance date. As of April 11, 2003, Coram has completed company-wide employee training, established new policies and procedures related to the privacy of protected healthcare information and has created, or is in the process of creating, business associates agreements in accordance with HIPAA regulations.

On February 20, 2003, the DHHS issued final rules governing the security of healthcare information. These rules specify a series of administrative, technical and physical security procedures for covered entities to use in order to assure the confidentiality of protected electronic healthcare information. The security standards will be effective April 21, 2003 with a mandatory compliance date of April 21, 2005 for most covered entities.

The company is evaluating the effect of HIPAA and taking steps to achieve compliance. At this time, management anticipates that the company will be able to fully comply with the HIPAA requirements that have been adopted. However, management cannot, at this time, estimate the cost of such compliance, nor can management estimate the cost of compliance with standards that have not yet been finalized by the DHHS. Although the healthcare information standards are likely to have a significant effect on the manner in which the company handles healthcare data and communicates with payers, at this time, management does not believe that the cost of compliance will have a material adverse effect on the company's business, financial condition, results of operations or cash flows.

Further statutes or regulations may be adopted which would impose additional requirements for Coram to be eligible to participate in federal and state reimbursement programs. Such new legislation or regulations may adversely affect Coram's business operations. There is significant national concern today about the availability and rising cost of healthcare in the United States. It is anticipated that new federal and/or state legislation will be passed and regulations adopted to attempt to provide broader and better healthcare services and to manage and contain costs. Management is unable to predict the content of any legislation or what, if any, changes may occur in the method and rates of Medicare and Medicaid reimbursement or other governmental regulations that may

affect the company's business, or whether such changes, if made, will have a material adverse effect on Coram's business, financial position and results of operations.

State Laws Regarding Fee Splitting, Provision of Medicine and Insurance. The laws of many states prohibit physicians from splitting fees with non-physicians and prohibit non-physician entities from practicing medicine. These laws vary from state to state and are enforced by courts and by regulatory authorities with broad discretion. Although management believes its operations, as currently conducted, are in material compliance with existing applicable laws, certain aspects of Coram's business operations have not been subject to state or federal regulatory interpretation. There can be no assurances that a review of Coram's business by courts or regulatory authorities will not result in determinations that could adversely affect the company's operations or that the healthcare regulatory environment will not change so as to restrict existing operations or expansion.

Most states have laws regulating insurance companies and HMOs. Coram is not

qualified in any state to engage in either the insurance or HMO business. As managed care penetration increases, state regulators are beginning to scrutinize the practices of and relationships among third-party payers, medical service providers and entities providing management and administrative services to medical service providers, especially with respect to risk-sharing arrangements by and among such providers. State regulators are also reviewing whether risk-bearing entities are subject to insurance or HMO regulation. Management believes that its practices are consistent with those of other direct healthcare service providers and do not constitute licensable HMO or insurance activities. To the extent such licenses may be required, Coram will make the necessary filings and registrations to achieve compliance with applicable laws. However, given the limited regulatory history with respect to such practices, there can be no assurances that states requiring licensure will not attempt to assert jurisdiction. If states pursue actions against Coram and/or its customers, Coram may be compelled to restructure or refrain from engaging in certain business practices.

Pharmacies and Home Health Agencies. Each of Coram's pharmacies is licensed in the states in which it is located and in the states where its products are delivered. Each of these pharmacies also has a Controlled Substances Registration Certificate issued by the Drug Enforcement Administration of the United States Department of Justice. Many states in which the company operates also require home infusion companies to be licensed as home health agencies. The failure of a branch facility to obtain, renew or maintain any required regulatory approvals or licenses could adversely affect the existing operations of that branch facility.

SoluNet Operations. The outsourced hospital compounding business is a relatively new healthcare delivery alternative and many State Boards of Pharmacy do not have specific regulations that govern the provision of pharmacy services provided through SoluNet's delivery model. However, based on consultations with legal counsel and review of state pharmacy laws, management is not aware of any prohibitions that currently preclude the provision of these services through SoluNet's existing model. Prior to entering a new market, SoluNet works proactively with the local State Boards of Pharmacy to obtain approval from the appropriate agencies prior to the provision of services which, in some cases, may delay entry into such markets. The failure of the company's SoluNet branch locations to obtain, renew or maintain required pharmacy regulatory approvals or licenses could have a material adverse effect on SoluNet's existing hospital contracts, operations and future business prospects. Additionally, there can be no assurances that new state pharmacy laws or further review and interpretations of existing pharmacy laws will not result in determinations that could adversely affect SoluNet's ability to continue to offer its services to existing hospital customers or expand its operations into new marketplaces.

Other Regulations. Coram's operations are subject to various state hazardous and medical waste disposal laws. The laws currently in effect do not classify most of the waste produced during the provision of the company's services to be hazardous, although disposal of non-hazardous medical waste is also subject to regulation. Occupational Safety and Health Administration ("OSHA") regulations require employers of workers who are occupationally exposed to blood or other potentially infectious materials to provide those workers with certain prescribed protections against bloodborne pathogens. The regulatory requirements apply to all healthcare facilities, including the company's branches, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. Furthermore, employers are required to provide hepatitis-B vaccinations, personal protective equipment, infection control training, post-exposure evaluation and follow-up, waste disposal policies and procedures, and engineering and work practice controls. Employers are also required to comply with certain recordkeeping requirements. Management believes that the company is in material compliance with the foregoing laws and

regulations.

Internal Compliance and Monitoring. Coram has implemented measures to promote compliance with applicable laws and regulations, including the promulgation of Coram's compliance program. Coram's compliance program reflects the company's commitment to providing high quality service in compliance with applicable laws and regulations and ethical business practices. Coram's Executive Compliance Steering Committee (the "Compliance Committee") oversees Coram's activities with respect to issues

of compliance and ethics and is responsible for implementing necessary actions to achieve the objectives of Coram's compliance program. The Compliance Committee includes the company's Executive Vice President, Chief Financial Officer and a Senior Vice President of Operations, along with representatives from Coram's legal, patient financial services and clinical operations departments. While Coram's internal compliance program is intended to address legal, human resource, regulatory and ethical compliance issues, no assurances can be given that Coram's business arrangements, present or past (or those of its predecessors or divested subsidiaries, affiliates or partnerships), will not be the subject of an investigation or prosecution by a federal or state governmental authority in the future. Such investigations could result in penalties, or any combination of the penalties discussed above, depending upon the agency involved in such investigation and prosecution.

Coram regularly monitors legislative developments and would seek to restructure a business arrangement if it was determined that such business relationship placed the company in material noncompliance with any applicable statute or regulation. The healthcare services industry will continue to be subject to substantial regulation at the federal and state levels, the scope and effect of which cannot be predicted by management. Any loss by Coram of its various federal certifications, its authorization to participate in the Medicare or Medicaid programs or its licenses under the laws of any state or other governmental authority from which a substantial portion of its revenue is derived would have a material adverse effect on its business. See Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations: Risk Factors" for further discussion.

EMPLOYEES

As of December 31, 2002, Coram had approximately 2,300 full-time equivalent employees (3,000 full and part-time employees). None of Coram's employees are currently represented by a labor union or other labor organization and no employees are covered by a collective bargaining agreement. Approximately 32% of the full-time employees are nurses and pharmacists, with the remainder consisting primarily of sales and marketing, billing and reimbursement, branch, clinical, financial and information systems personnel. Management believes that its employee relations are good.

ITEM 2. PROPERTIES

The company's corporate headquarters are located in Denver, Colorado and consist of approximately 28,000 square feet of office space leased through February 28, 2007. As of April 11, 2003, Coram maintained 77 branch locations throughout the United States and Canada, totaling approximately 0.8 million square feet of facility space with annual rent aggregating approximately $9.7 million. In addition, the company maintains a lease agreement that expires on

August 31, 2003 for space in Bannockburn, Illinois where the company's information systems equipment and personnel and the CTI business are located. Management is currently reviewing several real property alternatives for the existing Bannockburn, Illinois operations, including a proposed consolidation of such facility with the company's Mount Prospect, Illinois branch location. Moreover, management believes that a lease termination at any one facility would not materially affect the company's operations.

In September 2000, the Bankruptcy Court approved a Debtors' motion to reject four unexpired, non-residential real property leases and any associated subleases. The rejected leases included underutilized locations in: (i) Allentown, Pennsylvania; (ii) Denver, Colorado; (iii) Philadelphia, Pennsylvania; and (iv) Whippany, New Jersey. In December 2002, the Bankruptcy Court extended the Debtors' motion to assume or reject unexpired leases of non-residential real property up to and including June 30, 2003.

ITEM 3. LEGAL PROCEEDINGS

Bankruptcy Cases. On August 8, 2000, the Debtors commenced the Bankruptcy Cases. None of the company's other subsidiaries is a debtor in the Bankruptcy Cases and, other than the Resource Network Subsidiaries, none of the company's other subsidiaries is a debtor in any bankruptcy case. See Notes 3 and 4 to the company's Consolidated Financial Statements for further details.

Except as may otherwise be determined by the Bankruptcy Court, the protection afforded by Chapter 11 of the Bankruptcy Code generally provides for an automatic stay relative to any litigation proceedings pending against either or both of the Debtors. All such claims will be addressed through the proceedings within the Bankruptcy Cases. The automatic stay would not however, apply to actions brought against the company's non-debtor subsidiaries.

The Official Committee of the Equity Security Holders of Coram Healthcare Corporation. The Official Committee of the Equity Security Holders of Coram Healthcare Corporation (the "Equity Committee") objected to the Restated Joint Plan and the Second Joint Plan, contending, among other things, that the valuations upon which the Restated Joint Plan and the Second Joint Plan were premised and the underlying projections and assumptions were flawed. At various times during 2001, the Debtors and the Equity Committee

reviewed certain company information regarding, among other things, the Equity Committee's contentions. In connection therewith, on July 30, 2001, the Equity Committee filed a motion to terminate the Debtors' exclusivity period and file its own plan of reorganization; however, such motion was denied by the Bankruptcy Court.

Additionally, in February 2001, the Equity Committee filed a motion with the Bankruptcy Court seeking permission to bring a derivative lawsuit directly against the company's Chief Executive Officer, a former member of the CHC Board of Directors, Cerberus Partners, L.P., Cerberus Capital Management, L.P., Cerberus Associates, L.L.C. and Craig Court, Inc. (all the aforementioned corporate entities being parties to certain of the company's debt agreements or affiliates of such entities). The Equity Committee's proposed lawsuit alleged a collusive plan whereby the named parties conspired to devalue the company for the benefit of the company's creditors under the Securities Exchange Agreement. On February 26, 2001, the Bankruptcy Court denied the Equity Committee's motion without prejudice. In January 2002, the Equity Committee filed a substantially

similar motion with the Bankruptcy Court, which additionally named certain current CHC directors, the company's other noteholders and Harrison J. Goldin Associates, L.L.C. (sic) as possible defendants. On February 12, 2002, the Bankruptcy Court again denied the renewed motion without prejudice.

After the Debtors' exclusivity period to file their own plan of reorganization terminated, the Equity Committee filed a proposed plan of reorganization (the "Proposed Equity Committee Plan") in respect of the Debtors in the Bankruptcy Court on December 19, 2002. The Proposed Equity Committee Plan incorporates a variation of the aforementioned proposed derivative lawsuit. See Note 3 to the company's Consolidated Financial Statements for further discussion of the status of the Proposed Equity Committee Plan and the related Disclosure Statement within the Debtors' bankruptcy proceedings.

Management is aware that the Chapter 11 trustee continues to be engaged in settlement discussions and negotiations with the company's noteholders, the Equity Committee and other interested parties in connection with settling disputes and attempting to negotiate a consensual plan or plans of reorganization. Management cannot predict whether an amicable settlement will be reached, the ultimate outcome of the Proposed Equity Committee Plan, whether future objections of any party will be forthcoming to a proposed plan or plans of reorganization or how a future settlement or objections thereto might impact confirmation of any plan or plans of reorganization proposed by the Chapter 11 trustee, the Equity Committee or any other interested party.

Resource Network Subsidiaries' Bankruptcy. On August 19, 1999, a small group of parties with claims against the Resource Network Subsidiaries filed an involuntary petition pursuant to Section 303 of Chapter 11 of the Bankruptcy Code against Coram Resource Network, Inc. in the Bankruptcy Court. On November 12, 1999, the Resource Network Subsidiaries filed voluntary petitions under Chapter 11 of the Bankruptcy Code, Case No.s 99-2888 (MFW) and 99-2889 (MFW). The two cases were consolidated for administrative purposes and are now pending under the docket of In re Coram Resource Network Inc. and Coram Independent Practice Association, Inc., Case No. 99-2889 (MFW). On October 21, 2002, the Official Committee of Unsecured Creditors of Coram Resource Network, Inc. and Coram Independent Practice Association, Inc. (the "R-Net Creditors' Committee") filed a proposed Liquidating Chapter 11 Plan. A complete description of such plan is set forth in the disclosure statement filed contemporaneously therewith, which is available on the docket of the Resource Network Subsidiaries' bankruptcy cases at docket numbers 1003 and 1004. The Chapter 11 trustee has objected to the disclosure statement and a hearing thereon is currently scheduled for May 14, 2003.

On September 11, 2000, the Resource Network Subsidiaries filed a motion in the Bankruptcy Cases seeking, among other things, to have the Resource Network Subsidiaries' bankruptcy proceedings substantively consolidated with the Bankruptcy Cases. If this motion had been granted, the bankruptcy proceedings involving the Resource Network Subsidiaries and the Debtors would have been combined such that the assets and liabilities of the Resource Network Subsidiaries would have been joined with the assets and liabilities of the Debtors, the liabilities of the combined entity would have been satisfied from the combined assets and all intercompany claims would have been eliminated. Furthermore, the creditors of both proceedings would have voted on any reorganization plan for the combined entities. The Resource Network Subsidiaries and the Debtors engaged in discovery related to this substantive consolidation motion and then reached a settlement agreement in November 2000. The settlement agreement was approved by the Bankruptcy Court in December 2000 and, in connection therewith, the Debtors made a payment of $0.5 million to the Resource Network Subsidiaries' estate in January 2001 and the substantive consolidation motion was withdrawn with prejudice.

Notwithstanding the withdrawal of the substantive consolidation motion, the Resource Network Subsidiaries still maintain claims against each of the Debtors' estates and the company maintains claims against the Resource Network Subsidiaries' estate. Additionally, the R-Net Creditors' Committee filed objections to confirmation of the Second Joint Plan, as well as, a motion to lift the automatic stay in the Debtors' bankruptcy proceedings to pursue its claims against the Debtors. On June 6, 2002, the Bankruptcy Court granted the motion of the R-Net Creditors' Committee and lifted the automatic stay in the Bankruptcy Cases, thereby allowing the R-Net Creditors' Committee to pursue its claims against the Debtors.

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In November 2001, the R-Net Creditors' Committee filed a complaint in the Bankruptcy Court, subsequently amended twice, both on its own behalf and as assignee for causes of action that may belong to the Resource Network Subsidiaries, which named as defendants the Debtors, several non-debtor subsidiaries, several current and former directors, current executive officers of CHC and several other current and former employees of the company. This complaint, as amended, also named as defendants Cerberus Partners, L.P., Goldman Sachs Credit Partners L.P., Foothill Capital Corporation and Foothill Income Trust, L.P. (parties to certain of the company's debt agreements or affiliates of such entities). The complaint alleges that the defendants violated various state and federal laws in connection with alleged wrongdoings related to the operation and corporate structure of the Resource Network Subsidiaries, including, among other allegations, breach of fiduciary duty, conversion of assets and preferential payments to the detriment of the Resource Network Subsidiaries' estates, misrepresentation and fraud, conspiracy, fraudulent concealment and a pattern of racketeering activity. The complaint seeks damages in the amount of approximately $56 million and additional monetary and non-monetary damages, including the disallowance of the Debtors' claims against the Resource Network Subsidiaries, punitive damages and attorneys' fees. The Debtors objected to the complaint in the Bankruptcy Court because management believed that the complaint constituted an attempt to circumvent the automatic stay protecting the Debtors' estates; however, the Debtors' non-debtor subsidiaries have no such protection and, accordingly, they are vigorously contesting the allegations.

On June 17, 2002, the Chapter 11 trustee agreed to withdraw the Debtors' objections to the motion of the R-Net Creditors' Committee for leave of court to file their second amended complaint. On July 25, 2002, by stipulation between the Chapter 11 trustee and the R-Net Creditors' Committee, the Bankruptcy Court authorized the R-Net Creditors' Committee to file its second amended complaint. The parties to (i) the second amended complaint, (ii) the Debtors' motion for an order expunging the proofs of claims filed by the Resource Network Subsidiaries and (iii) the Resource Network Subsidiaries' objections to the Debtors' proofs of claims are proceeding with discovery under a case management order. On January 10, 2003, the United States District Court for the District of Delaware (the "District Court") granted motions by some, but not all, of the defendants for that court to withdraw the adversary proceedings from the jurisdiction of the Bankruptcy Court. Now pending before the District Court are motions by various defendants to dismiss some or all counts of the complaint. The company notified its insurance carrier of the second amended complaint and intends to avail itself of any appropriate insurance coverage for its directors and officers, who are also vigorously contesting the allegations.

Principally due to the early stages of the aforementioned Resource Network Subsidiaries' matters, the ultimate outcome thereof cannot be predicted with any degree of certainty, nor can management predict the amount of any recoveries

that the company may ultimately receive from its insurance carrier.

TBOB Enterprises, Inc. On July 17, 2000, TBOB Enterprises, Inc. ("TBOB") filed an arbitration demand against CHC (TBOB Enterprises, Inc. f/k/a Medical Management Services of Omaha, Inc. against Coram Healthcare Corporation, in the American Arbitration Association office in Dallas, Texas). In its demand, TBOB claims that the company breached its obligations under an agreement entered into by the parties in 1996 relating to a prior earn-out obligation of the company that originated from the acquisition of the claimant's prescription services business in 1993 by a wholly-owned subsidiary of the company. The company operated the business under the name Coram Prescription Services ("CPS") and the assets of the CPS business were sold on July 31, 2000. TBOB alleges, among other things, that the company impaired the earn-out payments due TBOB by improperly charging certain expenses to the CPS business and failing to fulfill the company's commitments to enhance the value of CPS by marketing its services. The TBOB demand alleges damages of more than $0.9 million, in addition to the final scheduled earn-out payment of approximately $1.3 million that was due in March 2001 (the latter amount is recorded in the company's Consolidated Financial Statements). Furthermore, pursuant to the underlying agreement with TBOB, additional liabilities may result from post-petition interest on the final scheduled earn-out payment. In accordance with SOP 90-7, such interest estimated to aggregate approximately $0.4 million at December 31, 2002 using the contractual interest rate of 18%, has not been recorded in the company's consolidated financial statements because TBOB's claim for interest may ultimately not be sustainable. TBOB reiterated its monetary demand through a proof of claim filed against CHC's estate for the aggregate amount of approximately $2.2 million (the scheduled earn-out payment plus the alleged damages). Any action relating to the final $1.3 million earn-out payment scheduled for March 2001, the alleged damages of $0.9 million and any interest accrued thereon have been stayed by operation of Chapter 11 of the Bankruptcy Code. On July 5, 2001, the company received a letter from TBOB's legal counsel requesting that the aforementioned arbitration remain in abeyance pending resolution of the Bankruptcy Cases. Management does not believe that final resolution of this matter will have a material adverse impact on the company's financial position or results of operations.

Internal Revenue Service ("IRS") Proposed Settlement. The company has reached a proposed settlement with the IRS regarding a notice of deficiency previously issued by such taxing authority and management is currently negotiating payment terms with the IRS. If ultimately approved, the proposed settlement would result in a federal tax liability of approximately $9.9 million, plus interest of

approximately $8.8 million at December 31, 2002, both of which have been recorded in the company's Consolidated Financial Statements. See Note 10 to the company's Consolidated Financial Statements for further details.

Alan Furst et al. v. Stephen Feinberg, et al. Alan Furst and Michael S. Harrison, individually and on behalf of all persons similarly situated, filed a complaint in the United States District Court for the District of New Jersey on November 8, 2000 and an Amended Class Action Complaint was filed on November 15, 2000, alleging that certain current and former officers and directors of the company and the company's principal lenders, Cerberus Partners, L.P., Foothill Capital Corporation and Goldman, Sachs & Co., implemented a scheme to perpetrate a fraud upon the stock market regarding the common stock of CHC. A Second Amended Class Action Complaint (the "Second Amended Complaint") was filed on

March 21, 2001, which removed all of the officers and directors of the company as defendants, except for the company's former Chief Executive Officer and a former member of CHC's Board of Directors, and continued to name Cerberus Partners, L.P., Foothill Capital Corporation and Goldman, Sachs & Co. as defendants. The plaintiffs' purported class action suit alleges that the defendants artificially depressed the trading price of the company's publicly traded shares and created the false impression that stockholders' equity was decreasing in value and was ultimately worthless. The plaintiffs further allege that members of the class sustained total investment losses of $50 million or more. On June 14, 2001, a third Amended Class Action Complaint (the "Third Amended Complaint") was filed naming the same defendants as the Second Amended Complaint. The plaintiffs' allegations in the Third Amended Complaint were substantially similar to the allegations in the Second Amended Complaint; however, the Third Amended Complaint eliminated references to the corporate assets of the company. All defendants moved to dismiss the Third Amended Complaint for failure to state a claim upon which relief can be granted and, in connection therewith, on May 6, 2002 the presiding judge granted the defendants' motion to dismiss, with prejudice and also denied plaintiffs' request for leave to replead. The plaintiffs filed a timely appeal to the United States Court of Appeals for the Third Circuit (the "Third Circuit") and filed their brief in support of their appeal with that court on July 24, 2002. The defendants filed their opposition brief on August 23, 2002 and the plaintiffs filed a reply brief on September 20, 2002. On December 18, 2002, the Third Circuit affirmed the lower court's order dismissing the case with prejudice. On December 30, 2002, the plaintiffs filed a petition for rehearing with the Third Circuit, however, such petition was denied on January 14, 2003. Management believes the company's financial obligation for the legal and professional fees related to this matter is limited to the deductible of the underlying insurance policy and, accordingly, such amount has been accrued in the company's Consolidated Financial Statements.

General. Management intends to vigorously defend the company and its subsidiaries in the matters described above. Nevertheless, due to the uncertainties inherent in litigation, including possible indemnification of other parties, the ultimate disposition of such matters cannot presently be determined. Adverse outcomes in some or all of the proceedings could have a material adverse effect on the financial position, results of operations and liquidity of the company.

The company and its subsidiaries are also parties to various other actions arising out of the normal course of their businesses, including employee claims, reviews of cost reports and billings submitted to Medicare and Medicaid, as well as, examinations by regulators such as Medicare and Medicaid fiscal intermediaries and the Centers for Medicare & Medicaid Services ("CMS"). Management believes that the ultimate resolution of such actions will not have a material adverse effect on the financial position, results of operations or liquidity of the company.

PricewaterhouseCoopers LLP. On July 7, 1997, the company filed suit against Price Waterhouse LLP (now known as PricewaterhouseCoopers LLP) in the Superior Court of San Francisco, California, seeking damages in excess of $165.0 million. As part of the settlement that resolved a case filed by the company against Caremark International, Inc. and Caremark, Inc. (collectively "Caremark"), Caremark assigned and transferred to the company all of Caremark's claims and causes of action against Caremark's independent auditors, PricewaterhouseCoopers LLP, related to the lawsuit filed by the company against Caremark. This assignment of claims includes claims for damages sustained by Caremark in defending and settling its lawsuit with the company. The case was dismissed from the California court because of inconvenience to witnesses with a right to re-file in Illinois. The company re-filed the lawsuit in state court in Illinois and PricewaterhouseCoopers LLP filed a motion to dismiss the company's lawsuit on several grounds, but its motion was denied on March 15, 1999.

PricewaterhouseCoopers LLP filed an additional motion to dismiss the lawsuit in May 1999 and that motion was dismissed on January 28, 2000. On April 19, 2001, PricewaterhouseCoopers LLP filed a motion for partial summary judgment with regard to a portion of Caremark's claims; however, this motion was subsequently denied. The lawsuit is currently in the discovery stage and a trial date is being scheduled. Management cannot predict the outcome of this litigation or whether there will be any recovery from PricewaterhouseCoopers LLP or its insurance carriers.

Government Regulation. Under the physician ownership and referral provisions of the Omnibus Budget Reconciliation Act of 1993 (commonly referred to as "Stark II"), it is unlawful for a physician to refer patients for certain designated health services reimbursable under the Medicare or Medicaid programs to an entity with which the physician and/or the physician's family, as defined under Stark II, has a financial relationship, unless the financial relationship fits within an exception enumerated in Stark II or

regulations promulgated thereunder. A "financial relationship" under Stark II is broadly defined as an ownership or investment interest in, or any type of compensation arrangement in which remuneration flows between the physician and the provider. The company has financial relationships with physicians and physician owned entities in the form of medical director agreements and service agreements pursuant to which the company provides pharmacy products. In each case, the relationship has been structured, based upon advice of legal counsel, using an arrangement management believes to be consistent with the applicable exceptions set forth in Stark II. In addition, the company is aware of certain referring physicians (or their immediate family members) that have had financial interests in the company through ownership of shares of the company's common stock. The Stark II law includes an exception for the ownership of publicly traded stock in companies with equity above certain levels. This exception of Stark II requires the issuing company to have stockholders' equity of at least $75 million either as of the end of its most recent fiscal year or on average over the last three fiscal years. Due principally to the extraordinary gains on troubled debt restructurings (see Note 9 to the company's Consolidated Financial Statements for further details), at December 31, 2002 the company's stockholders' equity was above the required level. As a result, the company is compliant with the Stark II public company exemption through the year ending December 31, 2003.

Management has been advised by legal counsel that a company whose stock is publicly traded has, as a practical matter, no reliable way to implement and maintain an effective compliance plan for addressing the requirements of Stark II other than complying with the public company exception. Accordingly, if the company's common stock remains publicly traded and its stockholders' equity falls below the required levels, the company would be forced to cease accepting referrals of patients covered by Medicare or Medicaid programs or run a significant risk of Stark II noncompliance. Because referrals of the company's patients with such government-sponsored benefit programs comprised approximately 25% of the company's consolidated net revenue for the years ended December 31, 2002 and 2001, discontinuing the acceptance of patients with government-sponsored benefit programs would have a material adverse effect on the financial condition, results of operations and cash flows of the company. Additionally, ceasing to accept such referrals could materially adversely affect the company's business reputation in the market as it may cause the company to be a less attractive provider to which a physician could refer his or her patients.

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

None.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON STOCK AND RELATED SECURITY HOLDER MATTERS

Prior to March 7, 2000, shares of the common stock of Coram Healthcare Corporation ("CHC") had been listed and traded on the New York Stock Exchange ("NYSE") under the symbol "CRH." Beginning on March 7, 2000, the shares have been traded through the Over the Counter Bulletin Board ("OCBB") maintained by the National Association of Securities Dealers, Inc., under the symbol "CRHE." Since the Debtors' filing under Chapter 11 of the Bankruptcy Code, CHC has been trading under the symbol "CRHEQ." The following table sets forth the high and low sales prices of the company's common stock, as reported on the OCBB for the two years ended December 31, 2002:

	HIGH	LOW
Year Ended December 31, 2002		
First Quarter.....	18/25	24/49
Second Quarter.....	3/4	2/5
Third Quarter.....	53/93	21/50
Fourth Quarter.....	31/50	16/39
Year Ended December 31, 2001		
First Quarter.....	4/5	11/50
Second Quarter.....	13/50	3/23
Third Quarter.....	9/25	7/40
Fourth Quarter.....	3/5	3/23

As of April 11, 2003, there were 4,286 record holders of the CHC's common stock. On April 11, 2003, the last bid for CHC's common stock on the OCBB was $0.64 per share and the last reported ask price was $0.66 per share. These quotations reflect inter-dealer prices without retail mark-up, mark-down or commission and may not necessarily represent actual transactions.

Trading of the CHC's common stock moved to the OCBB following an agreement between the company and the NYSE that shares of CHC's common stock no longer met the requirements for trading on the NYSE. Coram