PharMerica CORP
Form 10-K
February 09, 2012
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the year ended December 31, 2011

or

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

For the transition period from to .

Commission File Number: 001-33380

PHARMERICA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**87-0792558**

(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
1901 Campus Place	
Louisville, KY (Address of Principal Executive Offices)	40299 (Zip Code)

(502) 627-7000

(Registrant s Telephone Number, Including Area Code)

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

Title of each class	Name of exchange on which registered
Common stock $0.01 par value	New York Stock Exchange

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

N/A

(Title of class)

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ¨ No þ

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes þ 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 or any amendment to this Form 10-K. ¨

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

Large accelerated filer ¨	Accelerated filer þ
Non-accelerated filer ¨	Smaller reporting company ¨

(Do not check if a smaller reporting company)

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

The aggregate market value of the voting and non-voting common equity of the registrant held by non-affiliates as of June 30, 2011 was $.

Class of Common Stock	Outstanding at January 27, 2012
Common stock, $0.01 par value	29,443,872 shares

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates certain information by reference from registrant s definitive proxy statement for the 2012 annual meeting of stockholders, which proxy statement will be filed no later than 120 days after the close of the registrant s fiscal year ended December 31, 2011.

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PHARMERICA CORPORATION

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Part I

Item 1. Business

Overview

PharMerica Corporation (the Corporation) was formed on October 23, 2006, by Kindred Healthcare, Inc. (Kindred or Former Parent) and AmerisourceBergen Corporation (AmerisourceBergen) for the purpose of consummating the transactions contemplated by the Master Transaction Agreement dated October 25, 2006, as amended (the Master Agreement). Pursuant to the Master Agreement, Kindred and AmerisourceBergen, through a series of transactions (collectively, the Pharmacy Transaction), spun-off and combined their respective institutional pharmacy businesses, Kindred Pharmacy Services (KPS) and PharMerica Long-Term Care (PharMerica LTC), into a new, stand-alone, publicly traded company. The Pharmacy Transaction was consummated on July 31, 2007 (the Closing Date).

Unsolicited Tender Offer by Omnicare

On August 23, 2011, Omnicare, Inc. (Omnicare) made public an unsolicited proposal to acquire all of the outstanding shares of the Corporation s common stock for $15.00 per share in cash. After careful consideration with our financial and legal advisors, our Board of Directors determined unanimously that Omnicare s proposal undervalues the Corporation and was not in the best interests of our stockholders. On September 7, 2011, Omnicare, through its wholly-owned subsidiary, Philadelphia Acquisition Sub, Inc., commenced an unsolicited tender offer to purchase all of the outstanding shares of our common stock at $15.00 per share. On September 18, 2011, the Board again met with its financial and legal advisors, and after careful consideration our Board of Directors again unanimously recommended that our stockholders reject the offer and not tender their shares of our common stock because it believes that Omnicare s tender offer (i) undervalues the Corporation and its prospects, (ii) is illusory because it is subject to significant regulatory and other uncertainty, and (iii) is opportunistic based on the Corporation s then traded market value. On September 20, 2011, we filed with the Securities and Exchange Commission (SEC) a Recommendation/Solicitation Statement on Schedule 14D-9 detailing the recommendation of our Board of Directors in response to Omnicare s tender offer and the reasons it rejected the offer. Please refer to Part I, Item 3 Legal Proceedings and Note 6 to our consolidated financial statements included elsewhere in this report for a discussion of certain litigation commenced in respect of Omnicare s tender offer and related actions. On October 5, 2011, Omnicare extended the expiration date of its tender offer until 5:00 p.m., New York City time, on Friday, December 2, 2011, unless further extended. On December 5, 2011, Omnicare extended the expiration date of its tender offer until 5:00 p.m., New York City time, on Friday, January 20, 2012, unless further extended. On January 19, 2012, Omnicare extended the expiration date of its tender offer until 5:00p.m., New York City time, on Friday, January 27, 2012, unless further extended. On January 27, 2012, Omnicare extended the expiration of its tender offer until 5:00 p.m., New York City time, on Friday, February 17, 2012, unless further extended.

On August 25, 2011, after careful consideration and consultation with our financial and legal advisors, our Board of Directors adopted a rights plan and authorized the execution of the Rights Agreement, dated August 25, 2011 (the Rights Agreement), between the Corporation and Mellon Investor Services LLC, as Rights Agent. On August 25, 2011, the Board of Directors of the Corporation declared a dividend of one preferred share purchase right (a Right) for each outstanding share of common stock, par value $0.01 per share. The dividend was payable on September 6, 2011 to the stockholders of record on September 6, 2011. The Rights will expire on the earlier of August 25, 2021, or redemption by the Corporation. However, the rights will expire immediately at the final adjournment of the Corporation s 2012 annual meeting of stockholders if stockholder approval of the Rights Agreement has not been received prior to that time. The Rights Agreement is designed to prevent third parties from opportunistically acquiring the Corporation in a transaction that the Corporation s Board of Directors believes is not in the best interests of the Corporation s stockholders. In general terms, it works by imposing a significant penalty upon any person or group that acquires beneficial ownership of 15 percent or more of our outstanding common stock without the prior approval of our Board of Directors. The Corporation s Board of Directors believes the Rights Agreement has helped the Corporation s stockholders at this time by effectively

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preventing Omnicare from opportunistically acquiring the Corporation at a price that the Corporation s Board of Directors believes is inadequate for the reasons discussed above. The Rights Agreement has been narrowly tailored in a manner that our Board of Directors believes appropriately balances the interests of our stockholders in connection with what our Board of Directors considers an opportunistic, illusory and disadvantageous proposal, against the need to avoid excessive anti-takeover protections that ultimately may adversely impact stockholder value. The Rights Agreement should not interfere with any merger or other business combination approved by the Board of Directors.

Pursuant to the requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the regulations thereunder (the HSR Act), Omnicare filed a Notification and Report Form with the Antitrust Division of the U.S. Department of Justice (the Antitrust Division) and the Federal Trade Commission (the FTC) relating to its proposed acquisition of the Corporation on September 7, 2011. On or about September 19, 2011, the Corporation submitted a responsive Notification and Report Form with the Antitrust Division and the FTC. On September 22, 2011, the Corporation received a request for additional information from the FTC relating to the tender offer. On September 22, 2011, Omnicare also received a request for additional information from the FTC relating to the tender offer (the Second Request). The Second Request extended the waiting period under the HSR Act for 10 calendar days after the date Omnicare certified substantial compliance with the Second Request issued to Omnicare. On September 30, 2011, the FTC also issued a subpoena and civil investigative demand to the Corporation covering the same subject matter as the Second Request. The Corporation has produced a considerable amount of material in response to the FTC requests.

On November 18, 2011 Omnicare certified to the FTC that it had substantially complied with the Second Request. On November 18, 2011, Omnicare also executed a timing agreement with the FTC pursuant to which Omnicare agreed (i) to provide 14 days notice to the FTC prior to consummating its proposed acquisition and (ii) not to consummate its proposed acquisition prior to December 19, 2011 without the consent of the FTC. On December 2, 2011, Omnicare agreed with the FTC to extend the date prior to which Omnicare will not consummate its proposed acquisition to January 19, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 10, 2012, Omnicare agreed with the FTC that it will not consummate its proposed acquisition prior to January 26, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 27, 2012, the FTC issued an administrative complaint to block Omnicare s proposed acquisition of the Corporation. The complaint alleges that the proposed acquisition would be illegal and in violation of Section 15 of the FTC Act and Section 7 of the Clayton Act because it would harm competition and enable Omnicare to raise the price of drugs for Medicare Part D consumers and others. The case is scheduled to be heard before an administrative law judge at the FTC in June 2012.

The financial and outside legal advisors to the Corporation and Omnicare have met from time-to-time in an effort to agree upon an acceptable information sharing process relating to antitrust issues. On October 26, 2011, the Corporation and Omnicare and their respective outside legal advisors entered into a Confidentiality and Joint Defense Agreement (the Confidentiality and Joint Defense Agreement), which provides, among other things, for the parties to exchange on a confidential and privileged basis information in order to facilitate their respective assessment of the antitrust risk associated with a potential combination of the two companies. Although the Corporation s Board of Directors continues to believe that Omnicare s $15.00 per share offer undervalues the Corporation, the Corporation is engaging in this analytical process in order to further its understanding of Omnicare s assessment of the antitrust risk related to a business combination. The Confidentiality and Joint Defense Agreement does not obligate the Corporation to enter a transaction with Omnicare and there can be no assurance that this review will lead to a definitive merger agreement or any transaction between the two companies.

In connection with these matters, for the year ended December 31, 2011, we expensed $2.8 million of legal and advisory fees, which are included in integration, merger and acquisition related costs and other charges in the consolidated financial statements. We expect to incur significant additional costs in the future in connection with Omnicare s unsolicited tender offer.

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Institutional Pharmacy Business

The Corporation is the second largest institutional pharmacy services company in the United States based on revenues. We service healthcare facilities and also provide management pharmacy services to hospitals. The Corporation operates 95 institutional pharmacies in 44 states. The Corporation s customers are typically institutional healthcare providers, such as skilled nursing facilities, nursing centers, assisted living facilities, hospitals, and other long-term alternative care settings. The Corporation is generally the primary source of supply of pharmaceuticals to its customers. The Corporation also provides pharmacy management services to 91 hospitals in the United States.

Our core business provides pharmacy products and services to residents and patients in skilled nursing facilities, nursing centers, assisted living facilities, hospitals, and other long-term alternative care settings. We purchase, repackage, and dispense prescription and non-prescription pharmaceuticals in accordance with physician orders and deliver such medication to healthcare facilities for administration to individual patients and residents. Depending on the specific location, we service healthcare facilities typically within a radius of 120 miles or less of our pharmacy locations at least once each day. Each pharmacy provides 24-hour, seven-day per week on-call pharmacist services for emergency dispensing, delivery, and/or consultation with the facility s staff or the resident s attending physician. We also provide various supplemental healthcare services that complement our institutional pharmacy services.

We offer prescription and non-prescription pharmaceuticals to our customers through unit dose or modified unit dose packaging, dispensing, and delivery systems, typically in a 15 to 30 day supply. Unit dose medications are packaged for dispensing in individual doses as compared to bulk packaging used by most retail pharmacies. The customers we serve prefer the unit dose delivery system over the bulk delivery system employed by retail pharmacies because it improves control over the storage and ordering of drugs and reduces errors in drug administration in healthcare facilities. Nursing staff in our customers facilities administer the pharmaceuticals to individual patients and residents.

Our computerized dispensing and delivery systems are designed to improve efficiency and control over distribution of medications to patients and residents. We provide computerized physician orders and medication administration records for patients or residents on a monthly basis as requested. Data from these records are formulated into monthly management reports on patient and resident care and quality assurance. This system improves efficiencies in nursing time, reduces drug waste, and helps to improve patient outcomes.

Consultant Pharmacist Services

Federal and state regulations mandate that long-term care facilities, in addition to providing a source of pharmaceuticals, retain consultant pharmacist services to monitor and report on prescription drug therapy in order to maintain and improve the quality of resident care. On September 30, 2008, the United States Department of Health and Human Services Office of Inspector General (OIG) published OIG Supplemental Compliance Program Guidance for Nursing Homes. With quality of care being the first risk area identified, the supplemental guidance is part of a series of recent government efforts focused on improving quality of care at skilled nursing and long-term care facilities. The guidance contains compliance recommendations and an expanded discussion of risk areas. The guidance stressed that facilities must provide pharmaceutical services to meet the needs of each resident and should be mindful of potential quality of care problems when implementing policies and procedures on proper medication management. It further stated that facilities can reduce risk by educating staff on medication management and improper pharmacy kickbacks for consultant pharmacists and that facilities should review the total compensation paid to consultant pharmacists to ensure it is not structured in a way that reflects the volume or value of particular drugs prescribed or administered to residents.

In October 2011, Centers for Medicare and Medicaid Services (CMS) issued a proposed rule entitled Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Proposed Changes; Considering Changes to the Conditions of

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Participation for Long Term Care Facilities. In the proposed rule, CMS outlined its concerns, and requested comments, regarding certain contractual arrangements between Long Term Care (LTC) facilities, LTC pharmacies, consultant pharmacies, and pharmaceutical manufacturers. Specifically, CMS explained its perception that the provision of consulting services by pharmacy providers that supply medication to the facility leads to lack of independence of consultant pharmacists. CMS proposed requiring the independence of consultant pharmacists from LTC pharmacies. The Corporation believes that the proposed rule, which could require the independence of consultant pharmacists, may increase overall costs for payers and customers and reduce the quality of care and service to long-term care patients and residents. However, until CMS provides additional guidance, the Corporation is unable to fully evaluate the impact of the proposed changes in consultant pharmacist services.

We provide consultant pharmacist services that help our customers comply with the federal and state regulations applicable to nursing homes. Currently, we provide consultant services to approximately 73.4% of our patients serviced. The services offered by our consultant pharmacists include:

- Monthly reviews of each resident s drug regimen to assess the appropriateness and efficacy of drug therapies, including the review of medical records, monitoring drug interactions with other drugs or food, monitoring laboratory test results, and recommending alternative therapies;
- Participation on quality assurance and other committees of our customers, as required or requested by such customers;
- Monitoring and reporting on facility-wide drug utilization;
- Development and maintenance of pharmaceutical policy and procedure manuals; and
- Assistance with federal and state regulatory compliance pertaining to resident care.

Medical Records

The Corporation provides medical records services, which includes the completion and maintenance of medical record information for patients in the Corporation s customer s facilities. The medical records services include:

- Real-time access to medication and treatment administration records, physician order sheets and psychotropic drug monitoring sheets;
- Online ordering to save time and resources;
- A customized database with the medication profiles of each resident s medication safety, efficiency and regulatory compliance;
- Web-based individual patient records detailing each prescribed medicine; and
- Electronic medical records to improve information to make it more legible and instantaneous.

Ancillary Services

The Corporation provides intravenous drug therapy products and services to its customers. We provide intravenous (IV or infusion therapy) products and services to client facilities as well as hospice and home care patients. Infusion therapy consists of the product (a nutrient, antibiotic, chemotherapy, or other drugs in solution) and the intravenous administration of the product.

We prepare the product to be administered using proper equipment in an aseptic environment and then deliver the product to the facilities for administration by the nursing staff. Proper administration of IV drug therapy requires a highly trained nursing staff. Upon request, our nurse consultants provide an education and certification program on IV therapy to assure proper staff training and compliance with regulatory requirements in client facilities offering an IV therapy program.

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Hospital Pharmacy Management Services

We also provide hospital pharmacy management services. These services generally entail the overall management of the hospital pharmacy operations, including the ordering, receipt, storage, and dispensing of pharmaceuticals to the hospital s patients pursuant to the clinical guidelines established by the hospital. We offer the hospitals a wide range of regulatory and financial management services, including inventory control, budgetary analysis, staffing optimization, and assistance with obtaining and maintaining applicable regulatory licenses, certifications, and accreditations. We work with the hospitals to develop and implement pharmacy policies and procedures, including drug formulary development and utilization management. We also offer clinical pharmacy programs that encompass a wide range of drug therapy and disease management protocols, including protocols for anemia treatment, infectious diseases, wound care, nutritional support, renal dosing, and therapeutic substitution. The hospital pharmacy management services segment is comprised of a few customers, of which, our largest service is to the majority of the Kindred hospitals.

Additional business segment information is set forth in Part II, Item 8 Financial Statements and Note 12 Business Segment Data to the Consolidated Financial Statements of this annual report on Form 10-K.

Our Business Focus

Drive Scale Economies. We will focus on consistently providing quality pharmaceutical services to our customers at competitive prices and delivery of prescriptions in a timely and effective manner. Our business seeks to implement innovative and cost-effective solutions to improve the provision of medication to our customers and the residents and patients that they serve.

Focus on Organic Growth through New Sales and Client Retention. We aim to grow our business through expansion in our existing markets and by servicing new customers. We intend to grow organically. We believe our industry has underlying market growth potential attributable to both an increase in drug utilization as well as the general aging population of the United States.

Acquire Competitors. We also intend to expand our market share through selected geographic expansion in markets not currently served by us and through strategic acquisitions in existing and underserved markets. The Corporation currently operates in 44 states. We believe that there are growth opportunities in several other markets. There are numerous businesses in our markets, mostly small or regional companies, that lack the scale that we believe will be necessary to ultimately compete in a market that is national in scope. We intend to actively seek opportunities to acquire these companies. Since its formation, the Corporation has acquired seven institutional pharmacy businesses.

Sales and Marketing

We sell our products and services through a national sales force. Our sales force is organized along geographic lines to maximize coverage, manage costs, and align more effectively with our operating regions. Our sales representatives specialize in the products and services we offer and the markets in which we operate. Their knowledge permits us to meet the unique needs of our customers while maintaining profitable relationships.

Customers

Institutional Care Settings. Our customers are typically institutional healthcare providers, such as skilled nursing facilities, nursing centers, assisted living facilities, hospitals and other long-term alternative care settings. We are generally the primary source of supply of pharmaceuticals for our customers.

Our customers depend on institutional pharmacies like us to provide the necessary pharmacy products and services and to play an integral role in monitoring patient medication regimens and safety. We dispense pharmaceuticals in patient specific packaging in accordance with physician instructions.

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At December 31, 2011, we had contracts to provide pharmacy services to 339,498 licensed beds for patients in healthcare facilities throughout the country. We also have significant customer concentrations with facilities operated by Kindred. For the year ended December 31, 2011, Kindred institutional pharmacy contracts represented approximately 10.7% of the Corporation s total revenues.

Hospital Pharmacy Management Services. At December 31, 2011, the Corporation provided hospital pharmacy management services to Kindred and other customers at 91 locations. For the year ended December 31, 2011, revenues under the Kindred hospital pharmacy management service contracts represented approximately 3.0% of the Corporation s total revenues.

Suppliers/Inventory

On January 4, 2011, the Corporation entered into an Amended and Restated Prime Vendor Agreement for Long-Term Care Pharmacies by and between AmerisourceBergen Drug Corporation (ABDC), a wholly owned subsidiary of AmerisourceBergen Corporation, the Corporation, Pharmacy Corporation of America and Chem Rx Pharmacy Services, LLC (Chem Rx) (the Amended Prime Vendor Agreement). The Amended Prime Vendor Agreement became effective on January 1, 2011 and, upon its effectiveness, superseded in its entirety the Prime Vendor Agreement for Long-Term Care Pharmacies entered into as of August 1, 2007 between the Corporation and ABDC.

The Amended Prime Vendor Agreement incorporates Chem Rx and is otherwise substantially the same in scope except for modifications to select sourcing and rebate terms. The term of the Amended Prime Vendor Agreement was extended until September 30, 2013, with one-year automatic renewal periods unless either party provides prior notice of its intent not to renew.

We also obtain pharmaceutical and other products from contracts negotiated directly with pharmaceutical manufacturers for discounted prices. While the loss of a supplier could adversely affect our business if alternate sources of supply are unavailable, numerous sources of supply are generally available to us and we have not experienced any difficulty in obtaining pharmaceuticals or other products and supplies to conduct our business.

We seek to maintain an on-site inventory of pharmaceuticals and supplies to ensure prompt delivery to our customers. ABDC maintains local distribution facilities in most major geographic markets in which we operate.

Brand versus Generic

The pharmaceutical industry has been experiencing a higher level of brand-to-generic drug conversions. We believe the generic dispensing rate will continue to increase over time as the result of a large number of patent expirations in the near future.

The following table summarizes the generic drug dispensing rate:

2009	2010	2011
74.2%	75.5%	77.9%

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The following table summarizes the material brand-to-generic conversions expected to occur in 2012 through 2016:

2012	2013	2014	2015	2016
Lexapro (1Q)	Oxycontin (2Q)	Celebrex (2Q)	Namenda (1Q)	Crestor (3Q)
Seroquel IR (1Q)	Advair Diskus (3Q)	Humalog (2Q)	Abilify (2Q)	
Plavix (2Q)	Cymbalta (4Q)	Nexium (2Q)	Zyvox (2Q)	
Provigil (2Q)		Renvela (3Q)	Aggrenox (3Q)	
Actos (3Q)		Copaxone (4Q)	Lidoderm (4Q)	
Detrol (3Q)				
Detrol LA (3Q)				
Diovan (3Q)				
Diovan HCT (3Q)				
Geodon (3Q)				
Singulair (3Q)				
Xopenex (3Q)				

(Number in parentheses equals the quarter of conversion)

When a branded drug shifts to a generic, initial pricing of the generic drug in the market will vary depending on the number of manufacturers launching their generic version of the drug. Historically a shift from brand-to-generic decreased our revenue and improved our gross margin from sales of these classes of drugs during the initial time period a brand drug has a generic alternative. However, recent experience has indicated that the third-party payers may reduce their reimbursements to the Corporation faster than previously experienced. This acceleration in the reimbursement reduction has resulted in margin compression much earlier than we have historically experienced. Due to the unique nature of the brand-to-generic conversion, management cannot estimate the future financial impact of the brand-to-generic conversions on its results of operations.

Supplier and Manufacturer Rebates

We currently receive rebates from certain manufacturers and distributors of pharmaceutical products for achieving targets of market share or purchase volumes. Rebates are designed to prefer, protect, or maintain a manufacturer s products that are dispensed by the pharmacy under its formulary. Rebates for brand name products are generally based upon achieving a defined market share tier within a therapeutic class and can be based on either purchasing volumes or actual prescriptions dispensed. Rebates for generic products are more likely to be based on achieving purchasing volume requirements. For the years ended December 31, 2009, 2010 and 2011, rebates recorded as a reduction in cost of goods sold were $34.1 million, $37.2 million, and $75.5 million, respectively. The Corporation had $3.0 million, $3.3 million, and $6.1 million of rebates allocated as a reduction in inventory as of December 31, 2009, 2010, and 2011, respectively.

Information Technology

Computerized medical records and documentation are an integral part of our distribution system. We primarily utilize a proprietary information technology infrastructure that automates order entry of medications, dispensing of medications, invoicing, and payment processing. These systems provide consulting drug review, electronic medication management, medical records, and regulatory compliance information to help ensure patient safety. These systems also support verification of eligibility and electronic billing capabilities for the Corporation s pharmacies. They also provide order entry, shipment, billing, reimbursement and collection of service fees for medications, specialty services and other services rendered.

Based upon our electronic records, we are able to provide reports to our customers and management on patient care and quality assurance. These reports help to improve efficiency in patient care, reduce drug waste, and improve patient outcomes. We expect to continue to invest in technologies that help critical information access and system availability.

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On July 31, 2007, the Corporation entered into an Information Technology Services Agreement with Kindred Healthcare Operating, Inc. (KHOI), a wholly owned subsidiary of Kindred (the IT Services Agreement). Pursuant to the IT Services Agreement, KHOI is the Corporation s exclusive provider of certain information services and support related to information technology infrastructure and financial systems for a period of five years, ending on July 31, 2012. The services provided by KHOI include business services necessary to operate, manage, and support certain financial applications the Corporation uses, including enabling or supporting technology infrastructure and technology procurement services to support certain business functions. Such services include, among other matters, functions for financial management systems and payroll. The Corporation supports internally all other operating systems, including functions for order entry, pharmacy dispensing, clinical consulting, billing and collections, electronic medication management, sales and marketing, medical records management, human resources, internal and external customer call center support, and general business systems.

Except for certain services that will be provided at cost, KHOI will provide such services to the Corporation at its cost plus 10%, which will be the actual costs and expenses incurred in providing these services, including certain overhead costs and per hour costs of the KHOI employees providing the services. The initial term of the IT Services Agreement is five years. The IT Services Agreement will automatically renew for successive one-year periods after the expiration of the initial five year term, absent 120 days prior written notice of termination as provided for in the IT Services Agreement. The IT Services Agreement may be terminated by either party for cause and, in certain circumstances, by the Corporation in the event that KHOI undergoes a change of control to one of the Corporation s competitors. Following termination of the IT Services Agreement, KHOI must provide termination and expiration assistance for up to 180 days. The Corporation incurred $11.5 million, $11.1 million, and $10.8 million in fees to Kindred under the terms of the IT Services Agreement for the years ended December 31, 2009, 2010, and 2011, respectively.

Sources of Pharmacy Revenues

We receive payment for our services from third party payers, including Medicare Part D Plans, government reimbursement programs under Medicare and Medicaid, and non-government sources such as institutional healthcare providers, commercial insurance companies, health maintenance organizations, preferred provider organizations, and contracted providers. The sources and amounts of our revenues will be determined by a number of factors, including the mix of our customers patients, brand to generic conversions and the rates and charges of reimbursement among payers. Changes in our customers censuses, the case mix of the patients, brand and generic dispensing rates, and the payer mix among private pay, Medicare Part D and Medicaid, will affect our profitability.

In December 2003, Congress enacted the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) which included a major expansion of the Medicare program through the introduction of a prescription drug benefit (titled Medicare Part D) which is administered by commercial market insurers contracted with CMS. Under Medicare Part D, Medicare beneficiaries who are also entitled to benefits under a state Medicaid program (so called dual eligibles) now have their outpatient prescription drug costs covered by Medicare Part D, subject to certain limitations. Since January 1, 2006, most of the nursing center residents we serve whose drug costs were previously covered by state Medicaid programs are dual eligibles who qualify for Medicare Part D. Accordingly, Medicaid is no longer a primary payer for the pharmacy services provided to these residents. See Overview of Reimbursement.

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A summary of revenue by payer type for the years ended December 31, are as follows (dollars in millions):

	2009		2010		2011	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare Part D	$ 852.6	46.3%	$ 859.2	46.5%	$ 998.5	48.0%
Institutional healthcare providers	545.6	29.6	556.2	30.1	615.6	29.6
Medicaid	165.8	9.0	169.5	9.2	217.4	10.4
Private and other	122.4	6.6	107.3	5.8	92.7	4.5
Insured	91.5	5.0	89.8	4.9	90.0	4.3
Medicare	6.8	0.4	7.4	0.4	4.4	0.2
Hospital management fees	56.5	3.1	57.9	3.1	62.5	3.0
Total	$ 1,841.2	100.0%	$ 1,847.3	100.0%	$ 2,081.1	100.0%

Competition

We face a highly competitive environment in the institutional pharmacy market. In each geographic market, there are national, regional and local institutional pharmacies that provide services comparable to those offered by our pharmacies which may have greater financial and other resources than we do and may be more established in the markets they serve than we are. In addition, owners of skilled nursing facilities are also entering the institutional pharmacy market, particularly in areas of their geographic concentration. On a nationwide basis, there is one large competitor in the institutional pharmacy industry, Omnicare.

We believe that the competitive factors most important to our business are pricing, quality and the range of services offered, clinical expertise, ease of doing business with the provider and the ability to develop and maintain relationships with customers. Because relatively few barriers to entry exist in the local markets we serve, we have encountered and will continue to encounter substantial competition from local market entrants.

Patents, Trademarks and Licenses

We use a number of trademarks and service marks. All of the principal trademarks and service marks used in the course of our business have been registered in the United States or are the subject of pending applications for registration.

We have various proprietary products, processes, software and other intellectual property that are used either to facilitate the conduct of our business or that are made available as products or services to customers. We generally seek to protect such intellectual property through a combination of trade secret, patent and copyright laws and through confidentiality and other contractually imposed protections.

Although we believe that our products and processes do not infringe upon the intellectual property rights of any third parties, third parties may assert infringement claims against us from time to time.

Seasonality

Our largest customers in our institutional pharmacy segment are skilled nursing facilities. Both prescription and non-prescription drug sales at skilled nursing facilities are affected by the timing and severity of the cold/flu season and other seasonality of the long-term care facilities industry.

Working Capital

For information about the Corporation s practices relating to working capital items, see Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources .

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Employees

As of December 31, 2011, we had approximately 5,900 employees which included approximately 1,100 part-time employees. As a result of the acquisition of Chem Rx, the Corporation had approximately 500 employees that were covered by collective bargaining agreements as of December 31, 2011. As of December 31, 2011, we employed approximately 1,700 licensed pharmacists. We believe that our relationships with our employees are good.

Government Regulation

General

Extensive federal, state and local regulations govern institutional pharmacies and the healthcare facilities that they serve. These regulations cover licenses, staffing qualifications, conduct of operations, reimbursement, recordkeeping and documentation requirements and the confidentiality and security of health-related information. Our institutional pharmacies are also subject to federal and state laws that regulate financial arrangements between healthcare providers, including the federal anti-kickback statutes and the federal physician self-referral statutes.

Licensure, Certification and Regulation

States generally require that the state board of pharmacy license a pharmacy operating within the state. Many states also regulate out-of-state pharmacies that deliver prescription products to patients or residents in their states. We have the necessary pharmacy state licenses, or pending applications, for each pharmacy we operate. Our pharmacies are also registered with the appropriate federal and state authorities pursuant to statutes governing the regulation of controlled substances. In addition, pharmacists, nurses and other healthcare professionals who provide services on our behalf are in most cases required to obtain and maintain professional licenses and are subject to state regulation regarding professional standards of conduct.

The Drug Enforcement Agency (the DEA), the U.S. Food and Drug Administration (the FDA) and various state regulatory authorities regulate the distribution of pharmaceutical products and controlled substances. These laws impose a host of requirements on the pharmaceutical supply channel, including providers of institutional pharmacy services. Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, as a dispenser of controlled substances, we must register with the DEA, file reports of inventories and transactions and provide adequate security measures. In addition, we are required to comply with all the relevant requirements of the Controlled Substances Act for the transfer and shipment of pharmaceuticals. The FDA, DEA and state regulatory authorities have broad enforcement powers, including the ability to seize or recall products and impose significant criminal, civil and administrative sanctions for violations of these laws and regulations. We have received all necessary regulatory approvals and believe that our pharmacy operations are in substantial compliance with applicable federal and state good manufacturing practice requirements.

Client long-term care facilities are separately required to be licensed in the states in which they operate and, if serving Medicaid or Medicare patients, must be certified to be in compliance with applicable program participation requirements. Client facilities are also subject to the nursing home reforms of the Omnibus Budget Reconciliation Act of 1987, as amended, which imposed strict compliance standards relating to quality of care for facility operations, including vastly increased documentation and reporting requirements.

On September 20, 2006, CMS issued revised guidance to surveyors of long term care facilities regarding the survey protocol for review of pharmacy services provided in long-term care facilities participating in the Medicare and Medicaid programs. The new guidelines, which became effective December 18, 2006, expanded the areas and detail in which surveyors are to assess pharmacy services at the facility, including ordering, acquiring, receiving, storing, labeling, dispensing and disposing of all medications at the facility; the provision of medication-related information to health care professionals and residents; the process of identifying and

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addressing medication-related issues through medication regimen reviews and collaboration between the licensed consultant pharmacist, the facility and other healthcare professionals; and the provision, monitoring and use of medication-related devices. The guidelines also emphasize the important role of consultative services of pharmacists in promoting safe and effective medication use through the coordination of all aspects of pharmacy services provided to all residents within a facility. In addition, on September 30, 2008, the OIG published OIG Supplemental Compliance Program Guidance for Nursing Facilities. With quality of care being the first risk area identified, the supplemental guidance is part of a series of government efforts focused on improving quality of care at skilled nursing and long-term care facilities. The guidance contained new compliance recommendations and an expanded discussion of risk areas. The guidance stressed that facilities must provide pharmaceutical services to meet the needs of each resident and should be mindful of potential quality of care problems when implementing policies and procedures on proper medication management. It further stated that facilities can reduce risk by educating staff on medication management and improper pharmacy kickbacks for consultant pharmacists and that facilities should review the total compensation paid to consultant pharmacists to ensure it is not structured in a way that reflects the volume or value of particular drugs prescribed or administered to residents.

Laws Affecting Referrals and Business Practices

We are subject to federal and state laws that govern financial and other arrangements between healthcare providers. These laws prohibit certain direct and indirect payments or fee-splitting arrangements between healthcare providers that are designed to induce or encourage the referral of patients to, or the recommendation of, a particular provider for medical products and services. These laws include:

- the federal anti-kickback statute, which prohibits, among other things, knowingly or willfully soliciting, receiving, offering or paying remuneration including any kickback, bribe or rebate directly or indirectly in return for or to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other federal healthcare programs; and

- the federal Stark laws which prohibit, with limited exceptions, the referral of patients by physicians for certain designated health services, to an entity with which the physician has a financial relationship.

These laws impact the relationships that we may have with potential referral sources. We have a variety of relationships with potential referral sources, including hospitals and skilled nursing facilities with which we have contracted to provide pharmacy services. With respect to the anti-kickback statute, the OIG has enacted safe harbor regulations that outline practices that are deemed protected from prosecution. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, none of which is material to us, may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. In addition, as a means of providing guidance to healthcare providers, the OIG issues a variety of sub-regulatory guidance including Special Fraud Alerts, Special Advisory Bulletins, Advisory Opinions, and other compliance guidance documents. This guidance does not have the force of law, but identifies features of arrangements or transactions that may indicate that the arrangements or transactions violate the anti kickback statute or other federal health care laws. While we believe our practices comply with the anti-kickback statute, we cannot assure our practices that are outside of a safe harbor will not be found to violate the anti-kickback statute.

In addition to federal law, many states have enacted similar statutes which are not necessarily limited to items or services for which payment is made by federal healthcare programs. Violations of these laws may result in fines, imprisonment, denial of payment for services and exclusion from the Medicare and Medicaid programs and other state-funded programs.

Other provisions in the Social Security Act and in other federal and state laws authorize the imposition of penalties, including criminal and civil fines and exclusions from participation in Medicare, Medicaid and other

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federal healthcare programs for false claims, improper billing and other offenses. These laws include the federal False Claims Act, under which private parties have the right to bring qui tam whistleblower lawsuits against companies that submit false claims for payments to the government. Recent changes to the False Claims Act, expanding liability to certain additional parties and circumstances, may make these qui tam law lawsuits more prevalent. Some states have adopted similar state whistleblower and false claims laws.

In addition, a number of states have undertaken enforcement actions against pharmaceutical manufacturers involving pharmaceutical marketing programs, including looking at relationships with pharmacies and programs containing incentives for pharmacists to dispense one particular product rather than another. These enforcement actions arose under various state laws including fraud and abuse laws and consumer protection laws which generally prohibit false advertising, deceptive trade practices and the like.

In the ordinary course of business, we are regularly subject to inquiries, investigations and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations for regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments and fines. Such sanctions could have a material adverse effect on our financial position, results of operation and liquidity.

We believe our contract arrangements with other healthcare providers and our pharmaceutical suppliers and our pharmacy practices are in substantial compliance with applicable federal and state laws. These laws may, however, be interpreted in the future in a manner inconsistent with our interpretation and application.

State Laws Affecting Access to Services

Some states have enacted freedom of choice or any willing provider requirements as part of their state Medicaid programs or in separate legislation. These laws may preclude a nursing center from requiring their patients and residents to purchase pharmacy or other ancillary medical services or supplies from particular providers that have a supplier relationship with the nursing center. Limitations such as these may increase the competition which we face in providing services to nursing center residents.

HIPAA

The federal Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, mandates the adoption of regulations aimed at standardizing transaction formats and billing codes for documenting medical services, dealing with claims submissions and protecting the privacy and security of individually identifiable health information. HIPAA regulations that standardize transactions and code sets require standard formatting for healthcare providers, like us, that submit claims electronically.

The HIPAA privacy regulations apply to protected health information, or PHI which is defined generally as individually identifiable health information transmitted or maintained in any form or medium, excluding certain education records and student medical records. The privacy regulations seek to limit the use and disclosure of most paper and oral communications, as well as those in electronic form, regarding an individual s past, present or future physical or mental health or condition, or relating to the provision of healthcare to the individual or payment for that healthcare, if the individual can or may be identified by such information. HIPAA provides for the imposition of civil or criminal penalties if PHI is improperly disclosed.

HIPAA s security regulations require us to ensure the confidentiality, integrity and availability of all electronic protected health information that we create, receive, maintain or transmit. We must protect against reasonably anticipated threats or hazards to the security of such information and the unauthorized use or disclosure of such information.

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In addition to HIPAA, we are subject to state privacy laws and other state privacy or health information requirements not preempted by HIPAA, including those which may furnish greater privacy protection for individuals than HIPAA.

The scope of our operations involving health information is broad and the nature of those operations is complex. Although we believe that our contract arrangements with healthcare payers and providers and our business practices are in material compliance with applicable federal and state electronic transmissions, privacy and security of health information laws, the requirements of these laws, including HIPAA, are complicated and are subject to interpretation. In addition, state regulation of matters also covered by HIPAA, especially the privacy standards, is increasing, and determining which state laws are preempted by HIPAA is a matter of interpretation. Failure to comply with HIPAA or similar state laws could subject us to loss of customers, denial of the right to conduct business, civil damages, fines, criminal penalties and other enforcement actions.

The American Recovery and Reinvestment Act of 2009, commonly known as the Stimulus Package, changed several aspects of HIPAA including, without limitation, the following: (i) applies HIPAA security provisions and penalties directly to business associates of covered entities; (ii) requires certain notifications in the event of a security breach involving PHI; (iii) restricts certain unauthorized disclosures; (iv) changes the treatment of certain marketing activities; and (v) strengthens enforcement activities. In addition, the Secretary issued an interim final rule on August 24, 2009 that requires notifications for certain breaches of PHI. A final rule was submitted by the Secretary in 2010, but later withdrawn. The interim final rule will remain in effect until a final rule is issued.

2010 Health Care Legislation

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act and on March 30, 2010, President Obama signed into law the reconciliation law known as Health Care and Education Affordability Reconciliation Act (the Reconciliation Act), combined both Acts will hereinafter be referred to as 2010 Health Care Legislation. Four key provisions of the 2010 Health Care Legislation that are relevant to the Corporation are: (i) the gradual modification to the calculation of the Federal Upper Limit (FUL) for drug prices and the definition of Average Manufacturer s Price (AMP), (ii) the closure, over time, of the Part D coverage gap, which is otherwise known as the Donut Hole, (iii) short cycle dispensing requirements, and (iv) Biosimilar Biological Products. The constitutionality of the 2010 Health Care Legislation has been challenged in several Federal courts. At this time, the courts have split on the constitutionality of the 2010 Health Care Legislation. The appeal of these decisions has been accepted by the United States Supreme Court, which is expected to consider the case in 2012. Pending a final decision on the constitutionality of the legislation and the promulgation of regulations there under, the Corporation is unable to fully evaluate the impact of the 2010 Health Care Legislation.

FUL and AMP Changes

The 2010 Health Care Legislation amended the Deficit Reduction Act of 2005 (the DRA) to change the definition of the Federal Upper Limit or FUL by requiring the calculation of the FUL as no less than 175% of the weighted average, based on utilization, of the most recently reported monthly Average Manufacturer s Price or AMP for pharmaceutically and therapeutically equivalent multi-source drugs available through retail community pharmacies nationally.

In addition, the definition of AMP changed to reflect net sales only to drug wholesalers that distribute to retail community pharmacies and to retail community pharmacies that directly purchase from drug manufacturers. Further, the 2010 Health Care Legislation continues the current statutory exclusion of prompt pay discounts offered to wholesalers and adds three other exclusions to the AMP definition: i) bona fide services fees; ii) reimbursement for unsalable returned goods (recalled, expired, damaged, etc.); and iii) payments from and rebates/discounts to certain entities not conducting business as a wholesaler or retail community pharmacy.

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In addition to reporting monthly, the manufacturers are required to report the total number of units used to calculate each monthly AMP. CMS will use this information when it establishes FULs as a result of the new volume-weighted requirements pursuant to the 2010 Health Care Legislation.

In September 2011, CMS issued the first draft FUL reimbursement files for multiple source drugs, including the draft methodology used to calculate the FULs in accordance with the Health Care Legislation. These draft FUL prices are based on the manufacturer reported and certified July 2011 monthly AMP and AMP unit data. CMS continues to release this data monthly and is expected to do so going forward. CMS has not posted monthly AMPs for individual drugs, but only posted the weighted average of monthly AMPs in a FUL group and the calculation methodology.

On February 2, 2012, CMS issued proposed regulations further clarifying the AMP and FUL changes described above and indicated that the final rule would be issued sometime in 2013.

Until CMS provides final guidance and the industry adapts to this now public available pricing information, the Corporation is unable to fully evaluate the impact of the changes in FUL and AMP to its business.

Part D Coverage Gap

Starting on January 1, 2011, the Medicare Coverage Gap Discount Program (the Program) requires drug manufacturers to provide a 50% discount on the negotiated ingredient cost to certain Part D beneficiaries for certain drugs and biologics purchased during the coverage gap (this is exclusive of the pharmacy dispensing fee). In addition, the 2010 Health Care Legislation includes a requirement that closes or eliminates the coverage gap entirely by fiscal year 2020. The coverage gap will be eliminated by gradually reducing the coinsurance percentage for both drugs covered and not covered by the Program for each applicable beneficiary.

At this time, the Corporation is unable to fully evaluate the impact of the changes to the coverage gap to its business.

Short Cycle Dispensing

Pursuant to the 2010 Health Care Legislation, Prescription Drug Plans (PDPs) will be required, under Medicare Part D and Medicare Advantage prescription drug plans (Medicare Advantage or MAPDs) to utilize specific, uniform dispensing techniques, such as weekly, daily, or automated dose dispensing, when dispensing covered Part D drugs to beneficiaries who reside in a long-term care facility to reduce waste associated with 30 to 90 day prescriptions for such beneficiaries. This short cycle dispensing provision will take effect on January 1, 2013. On April 15, 2011, CMS issued final regulations pursuant to the 2010 Health Care Legislation requiring, beginning January 1, 2013, pharmacies dispensing to long-term care facilities to dispense no more than 14-day supplies of brand-name medications covered by Part D except in limited circumstances (i.e. solid oral doses of antibiotics and solid oral doses dispensed in original containers as indicated by the FDA or otherwise customarily dispensed in their original packaging to assist patients with compliance). The final regulations also provided clarity around what pharmacy costs should be included in the determination of the dispensing fee.

The Corporation is unable to fully evaluate the impact of the short cycle dispensing requirements on the Corporation s operating costs.

Biosimilar Biological Products

The 2010 Health Care Legislation creates a regulatory approval pathway for biosimilars (alternatively known as generics) for biological products. An innovator biological product will be granted 12 years of exclusivity. At this time, the Corporation is unable to fully evaluate the impact of the changes to biosimilars to its business.

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Overview of Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over and to certain disabled persons. Medicaid is a medical assistance program administered by each state that provides healthcare benefits to certain indigent patients. Within the Medicare and Medicaid statutory framework, there are substantial areas subject to administrative rulings, interpretations, and discretion that may affect payments made under Medicare and Medicaid.

We receive payment for our services from institutional healthcare providers, commercial Medicare Part D Plans, third party payer government reimbursement programs such as Medicare and Medicaid, and other non-government sources such as commercial insurance companies, health maintenance organizations, preferred provider organizations, and contracted providers. With respect to our skilled nursing facilities customers, their residents are covered by Medicare Part A, Part B and Part D Plans, Medicaid, insurance, and other private payers (including managed care).

Medicare

The Medicare program consists of four parts: (i) Medicare Part A, which covers, among other things, in-patient hospital, skilled nursing facilities, home healthcare, and certain other types of healthcare services; (ii) Medicare Part B, which covers physicians services, outpatient services, and certain items and services provided by medical suppliers such as intravenous therapy; (iii) a managed care option for beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, known as Medicare Part C or Medicare Advantage; and (iv) Medicare Part D, which provides coverage for prescription drugs that are not otherwise covered under Medicare Part A or Part B for those beneficiaries that enroll.

Part A

The Balanced Budget Act of 1997 (the BBA) mandated the Prospective Payment System (PPS) for Medicare-eligible enrolled residents in skilled nursing facilities. Under PPS, Medicare pays skilled nursing facilities a fixed fee per patient per day for extended care services to patients, covering substantially all items and services furnished during such enrollee s stay. Such services and items include pharmacy services and prescription drugs. We bill skilled nursing facilities based upon a negotiated fee schedule and are paid based on those contractual relationships. We do not receive direct payment from Medicare for patients covered under the Medicare Part A benefit. We classify the revenues recognized from these payers as Institutional Healthcare Providers.

Federal legislation continues to focus on reducing Medicare and Medicaid program expenditures. Such decreases may directly impact the Corporation s customers and their Medicare reimbursement. Given the changing nature of these rules, we are unable at this time to fully evaluate the impact on our business. Any evaluation of budgeting, cost-cutting, and financing of health care must also consider the new federal administration and the impact its proposed health care policies could have on any future cost considerations.

Part B

The MMA also changed the Medicare payment methodology and conditions for coverage of certain items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under Medicare Part B. The Corporation provides some of these products to its customers. The changes include, among other things, a new competitive bidding program. Beginning on January 1, 2011 in selected areas and for selected supplies, only suppliers that were winning bidders are eligible to provide services, at prices established as a result of the competitive bids, to Medicare beneficiaries. Enteral nutrients, equipment and supplies, and oxygen equipment and supplies are among the 10 categories of DMEPOS included in the first round of the competitive bidding process. The Corporation did not participate in the bidding process. The Corporation will continue to evaluate whether it will participate in additional rounds of the bidding, which CMS has not yet scheduled. Medicare Part B is not material to the Corporation, representing less than 0.5% of revenues.

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Part D

Medicare Part D provides coverage for prescription drugs that are not otherwise covered under Medicare Part A or Part B for those beneficiaries that enroll. Under Medicare Part D, beneficiaries may enroll in prescription drug plans offered by private commercial insurers who contract with CMS (or in a fallback plan offered on behalf of the government through a contractor, to the extent private entities fail to offer a plan in a given area), which provide coverage of outpatient prescription drugs (collectively, Part D Plans). Part D Plans include both plans providing the drug benefit on a standalone basis and Medicare Advantage plans providing drug coverage as a supplement to an existing medical benefit under that Medicare Advantage plan. Medicare beneficiaries generally have to pay a premium to enroll in a Part D Plan, with the premium amount varying from one Part D Plan to another, although CMS provides various federal subsidies to Part D Plans to reduce the cost to beneficiaries.

Part D Plans are required to make available certain drugs on their formularies. Dually-eligible residents in nursing centers generally are entitled to have their prescription drug costs covered by a Part D Plan, provided that the prescription drugs which they are taking are either on the Part D Plan s formulary or an exception to the Part D Plan s formulary is granted. CMS reviews the formularies of Part D Plans and requires these formularies to include the types of drugs most commonly used by Medicare beneficiaries. CMS also reviews the formulary exceptions criteria of the Part D Plans that provide for coverage of drugs determined by the Part D Plan to be medically appropriate for the enrollee; however there currently is not a separate formulary for long-term care residents.

We obtain reimbursement for drugs we provide to enrollees of the given Part D Plan in accordance with the terms of agreements negotiated between us and the Part D Plan. The Medicare Part D final rule prohibits Part D plans from paying for drugs and services not specifically called for by the BBA. Beginning in 2010, CMS required Part D sponsors to use pass-through pricing, based on the price actually received by the pharmacy for drugs, in order to determine beneficiary cost sharing and drug reporting. This change, and similar changes by CMS aimed at ensuring administrative costs are absorbed by the Pharmacy Benefit Manager (PBM) and not the government, may alter the way certain PBMs negotiate prices with pharmacies. Currently, we are unable to fully evaluate the impact of this change in pricing definition on the Corporation.

In addition, beginning January 2010, MIPPA required that all PDPs are required to provide prompt payment to pharmacies. PDP and MAPDs must pay clean claims to retail pharmacies within 14 days if submitted electronically or within 30 days otherwise.

Medicare Part D does not alter federal reimbursement for residents of nursing centers whose stay at the nursing center is covered under Medicare Part A. Accordingly, Medicare s fixed per diem payments to nursing centers under PPS will continue to include a portion attributable to the expected cost of drugs provided to such residents. We will, therefore, continue to receive reimbursement for drugs provided to such residents from the nursing center in accordance with the terms of our agreements with each nursing center.

In June 2009, CMS released a report indicating that approximately $41.0 million in Medicare Part D payments for prescription drugs, some dispensed by LTC pharmacies, were likely made incorrectly. CMS concluded many of the drugs, which were dispensed during Part A skilled nursing facility stays, should have been included in per diem payments under Medicare Part A. CMS stated it will focus on ensuring such improper payments do not occur in the future. We are unable to fully evaluate the impact of current and future federal initiatives aimed at eliminating these discrepancies.

In addition, we receive rebates from pharmaceutical manufacturers for undertaking certain activities that the manufacturers believe may increase the likelihood that we will dispense their products. CMS continues to question whether institutional pharmacies should be permitted to receive these access/performance rebates from manufacturers with respect to prescriptions covered under Medicare Part D, but has not prohibited the receipt of

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such rebates. CMS defines these as rebates a manufacturer provides to long-term care pharmacies that are designed to prefer, protect, or maintain that manufacturer s product selection by the long-term care pharmacy or to increase the volume of that manufacturer s products that are dispensed by the pharmacy under its formulary. CMS, in 2007, required PDPs to have policies and systems in place as part of their drug utilization management programs to protect beneficiaries and reduce costs when long-term care pharmacies receive incentives to move market share through access/performance rebates. The elimination or substantial reduction of manufacturer rebates, if not offset by other reimbursement, would have an adverse effect on our business.

Medicaid

The reimbursement rate for pharmacy services under Medicaid is determined on a state-by-state basis subject to review by CMS and applicable federal law. Although Medicaid programs vary from state to state, they generally provide for the payment of certain pharmacy services, up to established limits, at rates determined in accordance with each state s regulations. The federal Medicaid statute specifies a variety of requirements that a state plan must meet, including the requirements related to eligibility, coverage for services, payment, and admissions. For residents that are eligible for Medicaid only, and are not dual eligibles covered under Medicare Part D, we bill the individual state Medicaid program or in certain circumstances the state s designated managed care or other similar organizations. Federal regulations and the regulations of certain states establish upper limits for reimbursement of certain prescription drugs under Medicaid. In most states, pharmacy services are priced at the lower of usual and customary charges or cost, which generally is defined as a function of average wholesale price and may include a profit percentage plus a dispensing fee. Most states establish a fixed dispensing fee per prescription that is adjusted to reflect associated cost. Over the last several years, state Medicaid programs have lowered reimbursement through a variety of mechanisms, principally higher discounts off average wholesale price levels, expansion of the number of medications subject to federal upper limit pricing, and general reductions in contract payment methodology to pharmacies.

Environmental Matters

In operating our facilities, historically we have not encountered any material difficulties effecting compliance with applicable pollution control laws. No material capital expenditures for environmental control facilities are expected. While we cannot predict the effect which any future legislation, regulations or interpretations may have upon our operations, we do not anticipate any changes regarding pollution control laws that would have a material adverse impact on the Corporation.

Available Information

We make available free of charge on or through our web site, at www.pharmerica.com, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports as soon as reasonably practicable after such material is electronically filed with the SEC. Additionally, the public may read and copy any materials we file with the SEC at the SEC s Public Reference Room at 100 F Street, NE, Room 1580, Washington, D.C., 20549. Information regarding operation of the Public Reference Room is available by calling the SEC at 1-800-SEC-0330. Information that we file with the SEC is also available at the SEC s web site at www.sec.gov.

Our SEC filings are available to the public through the New York Stock Exchange (NYSE), 20 Broad Street, New York, New York, 10005. Our Common Stock is listed on the NYSE and trades under the symbol PMC .

The certifications of our Chief Executive Officer and Chief Financial Officer required under Section 302 of the Sarbanes-Oxley Act have been filed as Exhibits 31.1 and 31.2 to this Annual Report on Form 10-K.

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Item 1A. Risk Factors

You should consider carefully the risks described below, together with all of the other information, in evaluating our company and our common stock. If any of the risks described below actually occur, it could have a material adverse effect on our business, results of operations, financial position and stock price.

Risk Factors Relating to Unsolicited Tender Offer

The unsolicited takeover attempt by Omnicare will likely require us to incur significant additional costs.

On August 23, 2011, Omnicare made public an unsolicited proposal to acquire all of the outstanding shares of the Corporation s common stock for $15.00 per share in cash. After careful consideration and consultation with our financial and legal advisors, our Board of Directors determined unanimously that Omnicare s proposal undervalues the Corporation and was not in the best interests of our stockholders. On September 7, 2011, Omnicare, through its wholly-owned subsidiary, Philadelphia Acquisition Sub, Inc., commenced an unsolicited tender offer to purchase all of the outstanding shares of our common stock at $15.00 per share, net to seller in cash without interest thereon and less any required withholding tax. On September 18, 2011, the Board again met with its financial and legal advisors, and after careful consideration, our Board of Directors again unanimously recommended that our stockholders reject the offer and not tender their shares of our common stock because it believes that Omnicare s tender offer (i) undervalues the Corporation and its prospects, (ii) is illusory because it is subject to significant regulatory and other uncertainty, and (iii) is opportunistic based on the Corporation s then traded market value.

On October 26, 2011, the Corporation and Omnicare and their respective outside legal advisors entered into a Confidentiality and Joint Defense Agreement (the Confidentiality and Joint Defense Agreement) which provides, among other things, for the parties to exchange on a confidential and privileged basis information in order to facilitate their respective assessment of the antitrust risk associated with a potential combination of the two companies. Although the Corporation s Board of Directors continues to believe that Omnicare s $15.00 per share offer undervalues the Corporation, the Corporation is engaging in this analytical process in order to further its understanding of Omnicare s assessment of the antitrust risk related to a combination. The Confidentiality and Joint Defense Agreement does not obligate the Corporation to enter a transaction with Omnicare and there can be no assurance that this review will lead to a definitive merger agreement or any transaction between the two companies.

During the year ended December 31, 2011, the Corporation incurred $2.8 million in legal and advisory fees related to the evaluation of Omnicare s unsolicited tender offer and related actions. Responding to Omnicare s unsolicited tender offer and related actions is expected to result in the incurrence of significant additional expenses in the future, which may be material to the Corporation s financial position and results of operations.

Litigation relating to Omnicare s unsolicited tender offer may adversely impact our business.

On September 7, 2011, Omnicare filed a lawsuit in the Court of Chancery of the State of Delaware against the Corporation and the members of the Board of Directors, alleging that the members of the Board of Directors breached their fiduciary duties by refusing to negotiate with Omnicare, failing to inform themselves of the merits of the tender offer, and failing to consider and negotiate the tender offer.

On September 9, 2011, the Louisiana Municipal Police Employee s Retirement System (LMPERS) filed a lawsuit in the Court of Chancery of the State of Delaware, purportedly on behalf of a class of the Corporation stockholders against the Corporation and the members of the Board of Directors, alleging the members of the Board of Directors breached their fiduciary duties to the Corporation and its stockholders by adopting the Rights Agreement and failing to respond appropriately to the tender offer. LMPERS is seeking declaratory and injunctive relief, including an order certifying the case as a class action and an order enjoining application of the Rights Agreement.

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On September 22, 2011, Hugh F. Drummond as Trustee of the FBO Hugh F. Drummond Trust (Drummond) filed a lawsuit in the Court of Chancery of the State of Delaware, purportedly on behalf of a class of the Corporation s stockholders, against the Corporation and the members of the Board of Directors, alleging that the members of the Board of Directors breached their fiduciary duties to the Corporation and its stockholders by adopting the Rights Agreement and failing to respond appropriately to the tender offer. Drummond seeks declaratory and injunctive relief, including an order certifying the case as a class action and an order enjoining the directors and the Corporation from excluding strategic bidders, including Omnicare, imposing unreasonable preconditions on such strategic bidders, refusing to provide due diligence to strategic bidders, and conducting a limited sale process not designed to produce the best transaction for PharMerica s stockholders.

On October 3, 2011, the Court of Chancery of the State of Delaware entered an order consolidating the LMPERS and Drummond actions under the caption *In re PharMerica Corporation Shareholders Litigation*, Consolidated Civil Action No. 6851-CS. Plaintiffs in the consolidated action designated the complaint filed in the *Drummond* action as operative.

Other lawsuits may continue to be filed against us and our directors with similar or additional allegations. Such claims and any resultant litigation could subject us and our directors to liability, could be time consuming and expensive to defend, and could result in the diversion of the time and attention of our management and employees, any of which could have a material adverse impact on our business. See Legal Proceedings in Item 3 of Part I of this Annual Report for additional information regarding certain litigation relating to Omnicare s tender offer.

Omnicare s unsolicited tender offer is disruptive to our business.

The review and consideration of Omnicare s unsolicited tender offer and related actions by Omnicare and other stockholders, have been, and may continue to be, a significant distraction for our management and employees and have required, and may continue to require, the expenditure of significant time and resources by the Corporation. Omnicare s tender offer and related actions have also created uncertainty for the Corporation s employees, and this uncertainty may adversely affect our ability to retain key employees and hire new talent. Further, Omnicare s tender offer and related actions may create uncertainty for the Corporation s current and potential business partners. This uncertainty may cause our current and potential business partners to change or terminate their business relationship with us.

Uncertainty and speculation regarding Omnicare s tender offer and related actions may cause increased volatility in our stock price. In addition, if a transaction does not occur, or the market perceives that a transaction is unlikely to occur, our stock price may decline.

Omnicare s tender offer and related actions have created and may continue to create uncertainty for the Corporation s current and potential customers. This uncertainty may cause our current customers to change or terminate their business relationship with us and our potential customers not to commence a business relationship with us.

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Pursuant to the requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the regulations thereunder (the HSR Act), Omnicare filed a Notification and Report Form with the Antitrust Division of the U.S. Department of Justice (the Antitrust Division) and the Federal Trade Commission (the FTC) relating to its proposed acquisition of the Corporation on September 7, 2011. On or about September 19, 2011, the Corporation submitted a responsive Notification and Report Form with the Antitrust Division and the FTC. On September 22, 2011, the Corporation received a request for additional information from the FTC relating to the tender offer. On September 22, 2011, Omnicare also received a request for additional information from the FTC relating to the tender offer (the Second Request). The Second Request extended the waiting period under the HSR Act for 10 calendar days after the date Omnicare certified substantial compliance with the Second Request issued to Omnicare. On September 30, 2011 the FTC also issued a subpoena and civil investigative demand to the Corporation covering the same subject matter as the Second Request. The Corporation has produced a considerable amount of material in response to the FTC requests. Responding to the FTC s requests has required the expenditure of significant time and resources by the Corporation.

On November 18, 2011 Omnicare certified to the FTC that it had substantially complied with the Second Request. On November 18, 2011, Omnicare also executed a timing agreement with the FTC pursuant to which Omnicare agreed (i) to provide 14 days notice to the FTC prior to consummating its proposed acquisition and (ii) not to consummate its proposed acquisition prior to December 19, 2011 without the consent of the FTC. On December 2, 2011, Omnicare agreed with the FTC to extend the date prior to which Omnicare will not consummate its proposed acquisition to January 19, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 10, 2012, Omnicare agreed with the FTC that it will not consummate its proposed acquisition prior to January 26, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 27, 2012, the FTC issued an administrative complaint to block Omnicare s proposed acquisition of the Corporation. The complaint alleges that the proposed acquisition would be illegal and in violation of Section 15 of the FTC Act and Section 7 of the Clayton Act because it would harm competition and enable Omnicare to raise the price of drugs for Medicare Part D consumers and others. The case is scheduled to be heard before an administrative law judge at the FTC in June 2012.

The impact of Omnicare s tender offer due to these and other factors may undermine our business and have a material adverse affect on our results of operations.

Omnicare may undertake a proxy solicitation to elect its own slate of nominees for the Board of Directors at the Corporation s 2012 annual meeting of stockholders.

Omnicare has publicly stated that it may nominate and solicit proxies for the election of a slate of director nominees at the 2012 annual meeting of the Corporation s stockholders. If the Omnicare nominees are elected to our Board of Directors, the ability of management to work effectively and efficiently with our Board of Directors with respect to the day to day operations and development of the Corporation may be restricted, and as a result, the Corporation s business may be adversely impacted.

Risk Factors Relating to the Pharmacy Transaction

We may be charged for services and products from one of our former parents at amounts greater than those charged prior to the Pharmacy Transaction and those charged by third-parties.

Before the Pharmacy Transaction, our business was part of two separate public companies. Our former parent companies performed many corporate functions at costs that are less than those that are presently being charged. Kindred provides information technology services under the Information Technology Services Agreement. During the term of the Information Technology Services Agreement, we are not able to negotiate potentially better terms and thus this existing agreement could negatively impact our results of operations, financial position and competitive position.

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Risk Factors Relating to Our Business

Financial soundness of our customers and suppliers may adversely affect our results of operations.

If our customers operating and financial performance deteriorates, or if they are unable to make scheduled payments or obtain credit, our customers may not be able to pay, or may delay payment of, accounts receivable owed to us. Any inability of customers to pay us for our products and services may adversely affect our earnings and cash flow. Additionally, both state and federal government sponsored payers, as a result of budget deficits or reductions, may seek to reduce their health care expenditures resulting in the long-term care customers renegotiating their contracts with us. Any reduction in payments by such government sponsored payers may adversely affect our earnings and cash flow. Also some of customers real estate is owned by Real Estate Investment Trusts limiting their ability to renegotiate rental costs furthering their desire to reduce other controllable costs, such as pharmacy costs.

Intense competition may erode our profit margins.

The distribution of pharmaceuticals to healthcare facilities is highly competitive. In each geographic market, there are national, regional and local institutional pharmacies and numerous local retail pharmacies, which provide services comparable to those offered by our pharmacies and which may have greater financial and other resources than we do and may be more established in the markets they serve than we are. We also compete against regional and local pharmacies that specialize in long-term care. Many of our competitors have equal or greater resources and access to capital than the Corporation. In addition, local pharmacies have strong personal relationships with their customers. Because relatively few barriers to entry exist in the local markets we serve, we may encounter substantial competition from local market entrants. In addition, owners of skilled nursing facilities are also entering the institutional pharmacy market, particularly in areas of their geographic concentration. Consolidation within the institutional pharmacy industry may also lead to increased competition. Competitive pricing pressures may adversely affect our earnings and cash flow.

We compete based on innovation and service as well as price. To attract new clients and retain existing clients, we must continually meet service expectations of our clients and customers. We cannot be sure that we will continue to remain competitive with the service to our clients at our current levels of profitability.

If we lose relationships with one or more key pharmaceutical manufacturers or if the payments made or discounts provided by pharmaceutical manufacturers decline, our business and financial results could be adversely affected.

We maintain contractual relationships with numerous pharmaceutical manufacturers that may provide us with, among other things:

- discounts for drugs we purchase to be dispensed from our institutional pharmacies;
- rebates based upon distributions of drugs from our institutional pharmacies; and
- administrative fees for managing rebate programs.

If several of these contractual relationships are terminated or materially altered by the pharmaceutical manufacturers, our business and financial results could be materially adversely affected. In addition, formulary fee programs have been the subject of debate in federal and state legislatures and various other public and

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governmental forums. Changes in existing laws or regulations or in interpretations of existing laws or regulations or the adoption of new laws or regulations relating to any of these programs may materially adversely affect our business.

Our operating revenue and profitability may suffer upon the occurrence of the loss of certain customers.

We have a number of customers that own or operate numerous facilities in our institutional pharmacy segment. In addition, our hospital segment revenues are primarily derived from one large multi-facility customer. If we are not able to continue these relationships or are only able to continue these relationships on less favorable terms than the ones currently in place, our operating revenues and results of operations would be materially impacted. There can be no assurance that these customers will not terminate all or a portion of their contracts with the Corporation.

Our operating revenue and profitability may suffer because of an increase in our generic dispensing rate.

A shift in prescriptions dispensed from brand-to-generic and a decline in generic reimbursement rates from the PDP/PBMs may affect our operating revenue. When a branded drug shifts to a generic, initial pricing of the generic drug in the market will vary depending on the number of manufacturers launching their generic version of the drug. Historically a shift from brand-to-generic decreased our revenue and improved our gross margin from sales of these classes of drugs during the initial time period a brand drug has a generic alternative. However, recent experience has indicated that the third-party payers may reduce their reimbursements to the Corporation faster than previously experienced. This acceleration in the reimbursement reduction has resulted in margin compression as multi-source alternatives have become available much earlier than we have historically experienced. Due to the unique nature of the brand-to-generic conversion, management cannot estimate the future financial impact of the brand-to-generic conversions on its results of operations.

If we fail to comply with complex and rapidly evolving laws and regulations, we could suffer penalties, be required to pay substantial damages or make significant changes to our operations.

We are subject to numerous federal and state regulations. If we fail to comply with existing or future applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate our institutional pharmacies and our ability to participate in federal and state healthcare programs. As a consequence of the severe penalties we could face, we must devote significant operational and managerial resources to complying with these laws and regulations. Although we believe that we are substantially compliant with all existing statutes and regulations applicable to our business, different interpretations and enforcement policies of these laws and regulations could subject our current practices to allegations of impropriety or illegality, or could require us to make significant changes to our operations. In addition, we cannot predict the impact of future legislation and regulatory changes on our business or assure that we will be able to obtain or maintain the regulatory approvals required to operate our business.

As a result of political, economic, and regulatory influences, the healthcare delivery industry in the United States is under intense scrutiny and subject to fundamental changes. We cannot predict which reform proposals will be adopted, when they may be adopted, or what impact they may have on us.

The costs associated with complying with federal and state regulations could be significant and the failure to comply with any such legal requirements could have a material adverse effect on our financial condition, results of operations, and liquidity.

Pharmaceutical products can develop unexpected safety or efficacy concerns.

Unexpected safety or efficacy concerns can arise with respect to marketed products, whether or not scientifically justified, leading to product recalls, withdrawals or declining sales. If we fail to or do not promptly withdraw pharmaceutical products upon a recall by a drug manufacturer, our business and results of operations could be negatively impacted.

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Legal and regulatory changes reducing reimbursement rates for pharmaceuticals and/or medical treatments or services may reduce our profitability.

Both our own profit margins and the profit margins of our customers may be adversely affected by laws and regulations reducing reimbursement rates and charges. The sources and amounts of our revenues are determined by a number of factors, including licensed bed capacity and occupancy rates of our customers, the number of drugs administered to patients, the mix of pharmaceuticals dispensed, whether the drugs are brand or generic, and the rates of reimbursement among payers. Changes in the number of drugs administered to patients, as well as payer mix among private pay, Medicare and Medicaid, in our customers facilities will significantly affect our earnings and cash flow.

Further Modifications to the Medicare Part D Program May Reduce Revenue and Impose Additional Costs to the Industry.

The Medicare Prescription Drug Improvement and Modernization Act of 2003 or MMA included a major expansion of the Medicare program with the addition of a prescription drug benefit under the new Medicare Part D program. The continued impact of these regulations depends upon a variety of factors, including our ongoing relationships with the Part D Plans and the patient mix of our customers. Future modifications to the Medicare Part D program may reduce revenue and impose additional costs to the industry. In addition, we cannot assure you that Medicare Part D and the regulations promulgated under Medicare Part D will not have a material adverse effect on our institutional pharmacy business.

Reductions in manufacturer rebates may reduce our profitability.

Our pharmacies receive rebates from pharmaceutical manufacturers for undertaking certain activities that the manufacturers believe may increase the likelihood that their respective products will be dispensed. CMS has questioned whether long-term care pharmacies should be permitted to receive discounts, rebates and other price concessions from pharmaceutical manufacturers with respect to prescriptions covered under the Medicare Part D benefit. Our business would be adversely affected if CMS should take any action that has the effect of eliminating or significantly reducing the rebates that we receive from pharmaceutical manufacturers.

Changes in Medicaid Reimbursement may reduce our revenue.

The 2010 Health Care Legislation amended the Deficit Reduction Act of 2005 (the DRA) to change the definition of the FUL by requiring the calculation of the FUL as no less than 175% of the weighted average, based on utilization, of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent multi-source drugs available through retail community pharmacies nationally.

In addition, the definition of AMP changed to reflect net sales only to drug wholesalers that distribute to retail community pharmacies and to retail community pharmacies that directly purchase from drug manufacturers. Further, the 2010 Health Care Legislation continues the current statutory exclusion of prompt pay discounts offered to wholesalers and adds three other exclusions to the AMP definition; i) bona fide services fees; ii) reimbursement for unsalable returned goods (recalled, expired, damaged, etc.); and iii) payments from and rebates/discounts to certain entities not conducting business as a wholesaler or retail community pharmacy. In addition to reporting monthly, the manufacturers are required to report the total number of units used to calculate each monthly AMP. CMS will use this information when it establishes the FUL as a result of the new volume-weighted requirements pursuant to the 2010 Health Care Legislation.

In September 2011, CMS issued the first draft FUL reimbursement files for multiple source drugs, including the draft methodology used to calculate the FULs in accordance with the Health Care Legislation. These draft FUL prices are based on the manufacturer reported and certified July 2011 monthly AMP and AMP unit data. CMS continues to release this data monthly and is expected to do so going forward. CMS has not posted monthly AMPs for individual drugs, but only posted the weighted average of monthly AMPs in a FUL group and the calculation methodology.

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On February 2, 2012, CMS issued a proposed regulation further clarifying the AMP and FUL changes described above and indicated that the final rule will be issued sometime in 2013.

Until CMS provides final guidance and the industry adapts to this now public available pricing information, the Corporation is unable to fully evaluate the impact of the changes in FUL and AMP to its business.

Adverse results in material litigation matters or governmental inquiries could have a material adverse effect upon the Corporation s business.

The Corporation may from time to time become subject in the ordinary course of business to material legal action related to, among other things, intellectual property disputes, professional liability and employee-related matters, as well as inquiries from governmental agencies and Medicare or Medicaid carriers requesting comment and information on allegations of billing irregularities and other matters that are brought to their attention through billing audits, third parties or other sources. The health care industry is subject to substantial federal and state government regulation and audit. Legal actions could result in substantial monetary damages as well as damage to the Corporation s reputation with customers, which could have a material adverse effect upon our financial condition, results of operations, and liquidity.

If we or our customers fail to comply with Medicare and Medicaid regulations, we may be subjected to penalties or loss of eligibility to participate in these programs.

The Medicare and Medicaid programs are highly regulated. These programs are also subject to frequent and substantial changes. If we or our customers facilities fail to comply with applicable reimbursement laws and regulations, whether purposely or inadvertently, our reimbursement under these programs could be curtailed or reduced and our eligibility to continue to participate in these programs could be adversely affected. Federal or state governments may also impose other penalties on us for failure to comply with the applicable reimbursement regulations. Failure by our customers to comply with these or future laws and regulations could result in our inability to provide pharmacy services to these customers and their residents. We do not believe that we have taken any actions that could subject us to material penalties under these rules and regulations.

Among these laws is the federal anti-kickback statute. This statute prohibits anyone from knowingly and willfully soliciting, receiving, offering or paying any remuneration with the intent to refer, or to arrange for the referral or order of, services or items payable under a federal healthcare program. Courts have interpreted this statute broadly. Violations of the anti-kickback statute may be punished by a criminal fine of up to $25,000 for each violation or imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid. This law impacts the relationships that we may have with potential referral sources. We have a variety of relationships with potential referral sources, including hospitals and skilled nursing facilities with which we have contracted to provide pharmacy services. The Office of Inspector General at HHS, or OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse or waste. The OIG carries out this responsibility through a nationwide program of audits, investigations and inspections. The OIG has promulgated safe harbor regulations that outline practices that are deemed protected from prosecution under the anti-kickback statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. It cannot be assured that practices outside of a safe harbor will not be found to violate the anti- kickback statute.

The anti-kickback statute and similar state laws and regulations are expansive. We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality, or could require us to make changes in our facilities, equipment,

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personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial position, results of operations or prospects and our business reputation could suffer significantly. If we fail to comply with the anti-kickback statute or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. In addition, we are unable to predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or their impact.

Continuing government and private efforts to contain healthcare costs may reduce our future revenue.

We could be adversely affected by the continuing efforts of government and private payers to contain healthcare costs. To reduce healthcare costs, payers seek to lower reimbursement rates, limit the scope of covered services and negotiate reduced or capped pricing arrangements. While many of the proposed policy changes would require congressional approval to implement, we cannot assure you that reimbursement payments under governmental and private third party payer programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement under these programs. Any changes that lower reimbursement rates under Medicare, Medicaid or private pay programs could result in a substantial reduction in our net operating revenues. Our operating margins may continue to be under pressure because of deterioration in reimbursement, changes in payer mix and growth in operating expenses in excess of increases, if any, in payments by third party payers. For instance, the short cycle dispensing requirements set forth in the Patient Protection and Affordable Care Act, which would become effective January 2013, could impact our revenues and our profitability if the costs associated therewith are not fully reimbursed by the appropriate payers.

Healthcare reform could adversely affect the liquidity of our customers which would have an adverse effect on their ability to make timely payments to us for our products and services.

Healthcare reform and legislation may have an adverse effect on our business through decreasing funds available to our customers. Limitations or restrictions on Medicare and Medicaid payments to our customers could adversely impact the liquidity of our customers, resulting in their inability to pay us, or to timely pay us, for our products and services. This inability could have a material adverse effect on our financial position, results of operations, and liquidity.

The changing U.S. healthcare industry and increasing enforcement environment may negatively impact our business.

Our products and services are part of the structure of the healthcare financing and reimbursement system currently existing in the United States. In recent years, the healthcare industry has undergone significant changes in an effort to reduce costs and government spending. These changes include an increased reliance on managed care, cuts in Medicare funding affecting our healthcare provider customer base and consolidation of competitors, suppliers and customers.

We expect the healthcare industry to continue to change significantly in the future. Some of these potential changes, such as a reduction in governmental support of healthcare services or adverse changes in legislation or regulations governing prescription drug pricing, healthcare services or mandated benefits, may cause healthcare providers to reduce the amount of our products and services they purchase or the price they are willing to pay for our products and services. If we are unable to adjust to changes in the healthcare environment, it could have a material adverse effect on our financial position, results of operations and liquidity.

Further, both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the healthcare area. The OIG and the U.S. Department of Justice have, from

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time to time, established national enforcement initiatives, targeting all providers of a particular type, that focus on specific billing practices or other suspected areas of abuse. In addition, under the federal False Claims Act, private parties have the right to bring qui tam whistleblower lawsuits against companies that submit false claims for payments to the government. A number of states have adopted similar state whistleblower and false claims provisions. We do not believe that we have taken any actions that could subject us to material penalties under these provisions.

Further consolidation of managed care organizations and other third-party payers may adversely affect our profits.

Managed care organizations and other third-party payers have continued to consolidate in order to enhance their ability to influence the delivery of healthcare services. Consequently, the healthcare needs of a large percentage of the U.S. population are increasingly served by a small number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers for needed services. In addition, private payers, including managed care payers, increasingly are demanding discounted fee structures. To the extent that these organizations terminate us as a preferred provider, engage our competitors as a preferred or exclusive provider or demand discounted fee structures, our liquidity and results of operations could be materially and adversely affected.

Possible changes in, or our failure to satisfy our manufacturers rebate programs could adversely affect our results of operations.

We currently earn rebates from certain manufacturers of pharmaceutical products for meeting tiered market share and purchase volumes. There can be no assurance that pharmaceutical manufacturers will continue to offer these rebates or that they will not change the terms upon which rebates are offered. A decrease in prescription volumes dispensed or a decrease in the number of brand or generic drugs which participate in rebate programs and are used by the geriatric population could affect our ability to satisfy our manufacturers rebate programs. The termination of such programs or our failure to satisfy the criterion for earning rebates may have an adverse affect on our cost of goods sold, financial position, results of operations and liquidity.

If we or our customers fail to comply with licensure requirements, laws and regulations in respect of healthcare fraud or other applicable laws and regulations, we could suffer penalties or be required to make significant changes to our operations.

Our pharmacies must be licensed by the state board of pharmacy in the state in which they operate. Many states also regulate out-of-state pharmacies that are delivering prescription products to patients or residents in their states. The failure to obtain or renew any required regulatory approvals or licenses could adversely impact the operation of our business. In addition, the healthcare facilities we service are also subject to extensive federal, state and local regulations and are required to be licensed in the states in which they are located. The failure by these healthcare facilities to comply with these or future regulations or to obtain or renew any required licenses could result in our inability to provide pharmacy services to these facilities and their residents and could have a material adverse effect on our financial position, results of operations and liquidity.

While we believe that we are in substantial compliance with all applicable laws, many of the regulations applicable to us, including those relating to marketing incentives offered by pharmaceutical suppliers, and rebates paid by pharmaceutical manufacturers are vague or indefinite and have not been interpreted by the courts. They may be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that could require us to make changes in our operations. These changes may be material and may require the expenditure of material funds to implement. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid

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programs, bans on Medicare and Medicaid payments and fines. If we or our customers fail to comply with the extensive applicable laws and regulations, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations regardless of whether we have actually been involved in any violations or wrong-doing.

Federal and state medical privacy regulations may increase the costs of operations and expose us to civil and criminal sanctions.

We must comply with extensive federal and state requirements regarding the transmission and retention of health information. The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, referred to as HIPAA, was enacted to ensure that employees can retain and at times transfer their health insurance when they change jobs, to enhance the privacy and security of personal health information and to simplify healthcare administrative processes. HIPAA requires the adoption of standards for the exchange of electronic health information. Failure to comply with HIPAA could result in fines and penalties that could have a material adverse effect on our results of operations, financial condition, and liquidity.

Acquisitions, investments and strategic alliances that we have made or may make in the future may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

We have made and anticipate that we may continue to make acquisitions of, investments in and strategic alliances with complementary businesses to enable us to capitalize on our position in the geographic markets in which we operate and to expand our businesses in new geographic markets. At any particular time, we may be in various stages of assessment, discussion and negotiation with regard to one or more potential acquisitions, investments or strategic alliances, not all of which, if any, will be consummated. Our acquisition program and strategy has and may lead us to contemplate acquisitions of companies in bankruptcy or financial distress, all of which entail additional risks and uncertainties. Such risks and uncertainties include, without limitation, that, before assets may be acquired, customers may leave in search of more stable providers and vendors may terminate key relationships. Also, assets are generally acquired on an as is basis, with no recourse to the seller if the assets are not as valuable as may be represented. Finally, while bankrupt companies may be acquired for comparatively little money, the cost of continuing the operations may significantly exceed expectations. Our growth plans rely, in part, on the successful completion of future acquisitions. If we are unsuccessful, our business would suffer.

We intend to make public disclosure of pending and completed acquisitions when appropriate or required by applicable securities laws and regulations. Acquisitions may involve significant cash expenditures, debt incurrence, additional operating losses, amortization of certain intangible assets of acquired companies, and expenses that could have a material adverse effect on our financial position, results of operations and liquidity. Acquisitions involve numerous risks and uncertainties, including, without limitation:

- difficulties integrating acquired operations, personnel and information systems, or in realizing projected efficiencies and cost savings;
- diversion of management s time from existing operations;
- potential loss of key employees or customers of acquired companies;
- inaccurate assessment of assets and liabilities and exposure to undisclosed or unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare laws;
- increases in our indebtedness and a limitation on our ability to access additional capital when needed; and
- failure to operate acquired facilities profitably or to achieve improvements in their financial performance.

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Risks generally associated with our sophisticated information systems may adversely affect our results of operations.

We rely on sophisticated information systems in our business to obtain, rapidly process, analyze, and manage data to facilitate the dispensing of prescription and non-prescription pharmaceuticals in accordance with physician orders and deliver those medications to patients and long-term care residents on a timely basis; to manage the accurate billing and collections for thousands of customers; and to process payments to suppliers. Our business and results of operations may be materially adversely affected if these systems are interrupted or damaged or if they fail for an extended period of time.

We purchase a significant portion of our pharmaceutical products from one supplier AmerisourceBergen.

We are required to purchase a substantial amount of our pharmaceutical products from AmerisourceBergen, pursuant to the Amended Prime Vendor Agreement. If AmerisourceBergen fails to deliver products in accordance with the Amended Prime Vendor Agreement, there can be no assurance that our operations would not be disrupted or that we could obtain the products at similar cost or at all. In this event, failure to satisfy our customers requirements would result in defaults under these customer contracts subjecting us to damages and the potential termination of those contracts. Such events could have a material adverse effect on our financial position, results of operations and liquidity. In addition, under the terms of the Amended Prime Vendor Agreement, we are unable to negotiate potentially better pricing and other terms with other drug distributors which could negatively impact our competitive position.

Prescription volumes may decline, and our net revenues and profitability may be negatively impacted, if products are withdrawn from the market or if increased safety risk profiles of specific drugs result in utilization decreases.

We dispense significant volumes of drugs from our pharmacies. These volumes are the basis for our net revenues and profitability. When increased safety risk profiles of specific drugs or classes of drugs result in utilization decreases, physicians may cease writing or reduce the numbers of prescriptions written for these drugs. Additionally, negative press regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers. In cases where there are no acceptable prescription drug equivalents or alternatives for these prescription drugs, our volumes, net revenues, profitability and cash flows may decline.

We could be required to record a material non-cash charge to income if our recorded goodwill or intangible assets are impaired, or if we shorten intangible asset useful lives.

We have $214.2 million of goodwill and $100.2 million of recorded intangible assets, net, on our consolidated balance sheet as of December 31, 2011. Our intangible assets primarily represent the value of client relationships that were recorded from past acquisitions. Under current accounting rules, intangible assets are amortized over their useful lives. These assets may become impaired with the loss of significant clients. If the carrying amount of the assets exceeds the undiscounted pre-tax expected future cash flows from the lowest appropriate asset grouping, we would be required to record a non-cash impairment charge to our consolidated income statements in the amount the carrying value of these assets exceeds its fair value. In addition, while the intangible assets may not be impaired, the useful lives are subject to continual assessment, taking into account historical and expected losses of relationships that were in the base at time of acquisition. This assessment may result in a reduction of the remaining weighted average useful life of these assets, resulting in potentially significant increases to non-cash amortization expense that is charged to our consolidated income statements. A goodwill or intangible asset impairment charge, or a reduction of useful lives, could have a material effect on our results of operations. For the year ended December 31, 2011, we incurred a pre-tax impairment charge of $5.1 million or $0.11 per diluted common share as a result of non-renewal of certain customer contracts related to a pre-Pharmacy Transaction acquisition.

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We primarily obtain our information services from one provider. Failure to provide information services in a timely manner could cause delays in the delivery of our services, which could damage our reputation, cause us to lose customers and negatively impact our growth.

We obtain substantially all of our information services from Kindred, one of our former parent companies, pursuant to the IT Services Agreement. Kindred is not in the business of providing comprehensive information technology outsourcing services to third parties and does not have any significant prior experience providing comprehensive outsourcing information technology services for any third party. If Kindred or other third parties upon whom we are dependent fail to devote sufficient time and resources to us or if their performance is substandard, our business may be harmed. Any delays, malfunctions, inefficiencies or interruptions in these products or services could adversely affect the reliability or operation of our business, which could cause us to experience difficulty retaining current customers and attracting new customers. This could result in our failure to satisfy our customers requirements or comply with certain of our financial or regulatory reporting requirements, which could have a material adverse effect on our financial position, results of operations and liquidity.

We are highly dependent on our senior management team and our pharmacy professionals.

We are highly dependent upon the members of our senior management and our pharmacists and other pharmacy professionals. Our business is managed by a small number of senior management personnel. If we were unable to retain these persons, we might be materially adversely affected due to the limited pool of senior management personnel with significant experience in our industry. Accordingly, we believe we could experience significant difficulty in replacing key management personnel. We expect that any employment contracts we enter into with our key management personnel will be subject to termination without cause by either party. Moreover, although the majority of the members of our senior management team have significant experience in the industry, they will need time to fully assess and understand our business and operations. We can offer no assurance how long these members of senior management will choose to remain with us.

In addition, our continued success depends on our ability to attract and retain pharmacists and other pharmacy professionals. Competition for qualified pharmacists and other pharmacy professionals is intense. The loss of pharmacy personnel or the inability to attract or retain sufficient numbers of qualified pharmacy professionals could adversely affect our business. Although we generally have been able to meet our staffing requirements for pharmacists and other pharmacy professionals, our inability to do so in the future could have a material adverse effect on our financial position, results of operations and liquidity.

Risk Factors Relating to Ownership of Our Common Stock and Our Senior Secured Credit Facility

Certain provisions of our certificate of incorporation and bylaws and provisions of Delaware law could delay or prevent a change of control that stockholders favor.

Provisions of our certificate of incorporation and bylaws may discourage, delay or prevent a merger or other change of control that stockholders may consider favorable or may impede the ability of the holders of our common stock to change our management and Board of Directors. The provisions of our certificate of incorporation and bylaws, among other things:

- prohibit stockholder action except at an annual or special meeting. Specifically, this means our stockholders are unable to act by written consent;
- regulate how stockholders may present proposals or nominate directors for election at annual meetings of stockholders. Advance notice of such proposals or nominations is required;
- regulate how special meetings of stockholders may be called. Our stockholders do not have the right to call special meetings;
- authorize our board of directors to issue preferred stock in one or more series, without stockholder approval. Under this authority, our Board of Directors adopted the Rights Agreement which could

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ensure continuity of management by rendering it more difficult for a potential acquirer to obtain control of us; and

require an affirmative vote of the holders of three-quarters or more of the combined voting power of our common stock entitled to vote in the election of our directors in order for the stockholders to amend our bylaws.

In addition, because we have not chosen to be exempt from Section 203 of the Delaware General Corporation Law (DGCL), this provision could also delay or prevent a change of control that some stockholders may view as favorable. Section 203 provides that unless board and/or stockholder approval is obtained pursuant to the requirements of the statute, persons that acquire, or are affiliated with a person that acquires, more than 15% of the outstanding voting stock of a Delaware corporation shall not engage in any business combination with that corporation, including by merger, consolidation or acquisitions of additional shares, for a three-year period following the date on which that person or its affiliate becomes the holder of more than 15% of the corporation s outstanding voting stock.

On August 25, 2011, the Board of Directors adopted the Rights Agreement, providing for the distribution of one right for each share of common stock outstanding. Each right entitles the holder to purchase one one-thousandth (1/1000th) of a share of Series A Junior Preferred Stock, par value $0.01 per share, of the Corporation at a price of $45.00 per one one-thousandth (1/1000th) of a share, subject to adjustment. The Rights generally become exercisable at the discretion of the Board of Directors following a public announcement that 15% or more of the Corporation s common stock has been acquired or an intent to acquire has become apparent. The Rights will expire on the earlier of August 25, 2021 or redemption or exchange by the Corporation. However, the Rights will expire immediately at the final adjournment of the Corporation s 2012 annual meeting of stockholders if stockholder approval of the Rights Agreement has not been received prior to that time. Certain terms of the rights are subject to adjustment to prevent dilution. Further description and terms of the rights are set forth in the Rights Agreement dated August 25, 2011 between the Corporation and Mellon Investors Services LLC, as Rights Agent.

On August 25, 2011, the Board of Directors declared a dividend of one preferred share purchase right for each outstanding share of common stock. The dividend was paid on September 6, 2011 to the stockholders of record on September 6, 2011.

The market price and trading volume of our common stock may be volatile.

The market price of our common stock could fluctuate significantly for many reasons, including, without limitation the following:

as a result of the risk factors listed in this document;

actual or anticipated fluctuations in our results of operations;

for reasons unrelated to our specific performance, such as reports by industry analysts, investor perceptions, or negative announcements by our customers or competitors regarding their own performance;

changes in the outlook for a potential business combination transaction with Omnicare;

regulatory changes that could impact our business or that of our customers; and

general economic and industry conditions.

In addition, when the market price of a company s common stock drops significantly, stockholders often institute securities class action lawsuits against the company. A lawsuit against us could cause us to incur substantial costs and could divert the time and attention of our management and other resources.

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Acquisitions, investments and strategic alliances we may make in the future may need to be financed by borrowings from the senior secured credit facility for which funds may not be made available by certain participants.

We have made and anticipate that we may continue to make acquisitions of, investments in and strategic alliances with complementary businesses to enable us to capitalize on our position in the geographic markets in which we operate and to expand our business in new geographic markets. Our growth plans rely, in part, on the successful completion of future acquisitions. At any particular time, we may need to finance such acquisitions and strategic alliances with borrowings from our senior secured credit facility. The financial markets are very volatile and certain participants in our senior secured credit facility may not be able to participate in funding their commitments under the revolving line of credit. If we are unsuccessful in obtaining the financing, our business would be impacted.

We are exposed to interest rate changes.

We are exposed to market risk related to changes in interest rates. As of December 31, 2011, we had outstanding debt of $300.0 million, all of which was subject to variable rates of interest. See Item 7A., Quantitative and Qualitative Disclosures about Market Risk.

We have indebtedness, which restricts our ability to pay cash dividends and has a negative impact on our financing options and liquidity.

We have $300.0 million in indebtednesses outstanding as of December 31, 2011 under our senior secured credit facility and revolver.

The credit agreement contains customary restrictions, requirements and other limitations on our ability to incur indebtedness. The senior secured credit facility also contains financial covenants that require us to satisfy certain financial tests and maintain certain financial ratios, including a maximum of debt to EBITDA ratio. The senior secured credit facility limits our ability to declare and pay dividends or other distributions on our shares of common stock. If our lenders permit us to declare dividends, the dividend amounts, if any, will be determined by our Board of Directors, which will consider a number of factors, including our financial condition, capital requirements, funds generated from operations, future business prospects, applicable contractual restrictions and any other factors our Board of Directors may deem relevant. The amount of this outstanding indebtedness could limit our ability to pay cash dividends and to obtain additional financing in the future for working capital, capital expenditure and acquisition purposes. A significant portion of our cash flows will be dedicated to debt service and will be unavailable for investment, capital expenditures or other operating expenses.

As a result of these and other factors, we cannot assure you that our business will generate sufficient cash flows from operations or that future borrowings will be available to us in amounts sufficient to enable us to pay our indebtedness or to fund our other liquidity needs. If we do not generate or are unable to borrow sufficient amounts of cash on satisfactory terms to meet these needs, we may need to seek to refinance all or a portion of our indebtedness on or before maturity, sell assets, curtail discretionary capital expenditures or seek additional capital. There can be no assurance that additional capital will be available to us on acceptable terms, or at all, which could adversely impact our business, results of operations, liquidity, capital resources, and financial position.

Our ability to pay dividends is limited by our financial results and we do not anticipate paying any distributions in the foreseeable future.

We anticipate that future earnings will be used principally to support operations and finance the growth of our business. Thus, we do not intend to pay dividends or other cash distributions on our common stock in the foreseeable future. See Part II, Item 5 Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

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We entered into a senior secured credit facility providing for both term and revolving credit borrowings. Our ability to make payments on our existing and future debt and to fund working capital needs and planned capital expenditures will depend on our ability to generate cash in the future, which is largely subject to general economic, financial, competitive, regulatory, legislative and other factors that are beyond our control. Cost containment and lower reimbursement levels relative to increases in cost by third party payers, including federal and state governments, could have a significant negative impact on our business and on our cash flows. Our operating margins continue to be under pressure because of continuing reimbursement and regulatory changes and growth in our operating expenses, such as product and labor costs.

See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources.

Item 1B. Unresolved Staff Comments

None.

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Item 2. Properties

We have facilities including offices and key operating facilities (e.g. institutional pharmacies) in various locations throughout the United States. The Corporation s corporate headquarters are located in Louisville, Kentucky. In addition to the institutional pharmacies listed below, the Corporation also has four facilities throughout the nation with several overhead and administrative functions. As of December 31, 2011, all facilities were leased. We consider all of these facilities to be suitable, adequate, and are utilized at full capacity by the institutional pharmacy business segment.

The following table presents certain information with respect to operating leases of our institutional pharmacies identified by the Corporation as properties as of December 31, 2011:

State	# of Facilities	Square Footage	State	# of Facilities	Square Footage
Alabama	2	20,330	Mississippi	1	11,600
Arizona	2	21,436	Missouri	1	4,090
Arkansas	1	6,850	Montana	1	2,440
California	10	100,451	Nebraska	1	5,120
Colorado	2	14,067	Nevada	1	7,000
Connecticut	1	15,600	New Hamphire	1	7,500
Delaware	1	5,739	New Jersey	1	14,309
Florida	6	67,112	New Mexico	1	4,798
Georgia	2	33,202	New York	2	56,738
Hawaii	5	15,506	North Carolina	4	26,950
Idaho	1	4,031	Ohio	4	41,582
Illinois	1	15,495	Pennsylvania	7	62,380
Indiana	1	20,386	Rhode Island	1	9,415
Iowa	1	6,250	South Carolina	1	15,550
Kansas	1	9,977	South Dakota	2	12,050
Kentucky	2	43,500	Tennessee	3	28,862
Louisiana	1	4,914	Texas	9	69,179
Maine	1	10,200	Utah	1	8,002
Maryland	1	10,744	Virginia	3	23,647
Massachusetts	1	53,111	Washington	2	14,792
Michigan	2	13,185	West Virginia	1	1,419
Minnesota	1	13,871	Wisconsin	1	11,068

Item 3. Legal Proceedings

On September 7, 2011 Omnicare filed a lawsuit in the Court of Chancery of the State of Delaware against the Corporation and the members of the Corporation s Board of Directors, styled Omnicare, Inc. v. PharMerica Corporation, et al., Civil Action No. 6841-CS. In the action, Omnicare alleges that the members of the Board of Directors breached their fiduciary duties to the Corporation and its stockholders by, among other things, refusing to negotiate with Omnicare, failing to inform themselves of the merits of the tender offer, and failing to consider and negotiate the tender offer. Omnicare seeks declaratory and injunctive relief, including an order requiring the Board of Directors to render the Rights Agreement, dated August 25, 2011 (the Rights Agreement), between the Corporation and Mellon Investor Services LLC, as Rights Agent, and Section 203 of the Delaware General Corporation Law (DGCL) inapplicable to Omnicare s tender offer and proposed merger. The Corporation and its directors believe that the claims made by Omnicare are without merit and intend to defend them vigorously.

On September 9, 2011, the Louisiana Municipal Police Employees Retirement System (LMPERS) filed a lawsuit in the Court of Chancery of the State of Delaware, purportedly on behalf of a class of the Corporation s stockholders, against the Corporation and the members of the Corporation s Board of Directors, styled Louisiana

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Municipal Police Employees Retirement System v. Frank Collins, et al., Civil Action No. 6851-CS. In the action, LMPERS alleges that the members of the Board of Directors breached their fiduciary duties to the Corporation and its stockholders by, among other things, adopting the Rights Agreement and failing to respond appropriately to the tender offer. LMPERS seeks declaratory and injunctive relief, including an order certifying the case as a class action and an order enjoining application of the Rights Agreement and Section 203 of the DGCL to the tender offer and proposed merger.

On September 22, 2011, Hugh F. Drummond as Trustee of the FBO Hugh F. Drummond Trust (Drummond) filed a lawsuit in the Court of Chancery of the State of Delaware, purportedly on behalf of a class of the Corporation s stockholders, against the Corporation and the members of the Corporation s Board of Directors, styled Hugh F. Drummond as Trustee of the FBO Hugh F. Drummond Trust v. PharMerica Corp., et al., Civil Action No. 6882. In the action, Drummond alleges that the members of the Board of Directors breached their fiduciary duties to the Corporation and its stockholders by, among other things, adopting the Rights Agreement and failing to respond appropriately to the tender offer. Drummond seeks declaratory and injunctive relief, including an order certifying the case as a class action and an order enjoining the directors and the Corporation from excluding strategic bidders, including Omnicare, imposing unreasonable preconditions on such strategic bidders, refusing to provide due diligence to strategic bidders, and conducting a limited sale process not designed to produce the best transaction for PharMerica s stockholders.

On October 3, 2011, the Court of Chancery of the State of Delaware entered an order consolidating the LMPERS and Drummond actions under the caption *In re PharMerica Corporation Shareholders Litigation*, Consolidated Civil Action No. 6851-CS. Plaintiffs in the consolidated action designated the complaint filed in the *Drummond* action as operative. The Corporation and its directors believe that the claims made by LMPERS and Drummond are without merit and intend to defend the consolidated action vigorously.

Pursuant to the requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the regulations thereunder (the HSR Act), Omnicare filed a Notification and Report Form with the Antitrust Division of the U.S. Department of Justice (the Antitrust Division) and the Federal Trade Commission (the FTC) relating to its proposed acquisition of the Corporation on September 7, 2011. On or about September 19, 2011, the Corporation submitted a responsive Notification and Report Form with the Antitrust Division and the FTC. On September 22, 2011, the Corporation received a request for additional information from the FTC relating to the tender offer. On September 22, 2011, Omnicare also received a request for additional information from the FTC relating to the tender offer (the Second Request). The Second Request extended the waiting period under the HSR Act for 10 calendar days after the date Omnicare certified substantial compliance with the Second Request issued to Omnicare. On September 30, 2011, the FTC also issued a subpoena and civil investigative demand to the Corporation covering the same subject matter as the Second Request. The Corporation has produced a considerable amount of material in response to the FTC requests.

On November 18, 2011 Omnicare certified to the FTC that it had substantially complied with the Second Request. On November 18, 2011, Omnicare also executed a timing agreement with the FTC pursuant to which

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Omnicare agreed (i) to provide 14 days notice to the FTC prior to consummating its proposed acquisition and (ii) not to consummate its proposed acquisition prior to December 19, 2011 without the consent of the FTC. On December 2, 2011, Omnicare agreed with the FTC to extend the date prior to which Omnicare will not consummate its proposed acquisition to January 19, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 10, 2012, Omnicare agreed with the FTC that it will not consummate its proposed acquisition prior to January 26, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 27, 2012, the FTC issued an administrative complaint to block Omnicare s proposed acquisition of the Corporation. The complaint alleges that the proposed acquisition would be illegal and in violation of Section 15 of the FTC Act and Section 7 of the Clayton Act because it would harm competition and enable Omnicare to raise the price of drugs for Medicare Part D consumers and others. The case is scheduled to be heard before an administrative law judge at the FTC in June 2012.

The Corporation is responding to an investigation by the U.S. Attorney for the Eastern District of Wisconsin and by the Drug Enforcement Agency into the Corporation s alleged failure to comply with various laws and regulations relating to the control and dispensing of certain controlled substances as well as the potential filing of false claims for payments of certain controlled substances that the Corporation dispensed to nursing home residents. The Corporation has been informed that the government believes that the claims at issue were not eligible for payment due to the alleged non-compliance with various Medicare, Medicaid and other laws and regulations relating to the dispensing, control, sale, billing and reimbursement for such controlled substances. The Corporation denies the allegations made by the government and will defend itself in the event any actions are brought by the government. At this time, we are unable to estimate the outcome of the investigation. If the government brings claims and the Corporation is not successful in defending them, it could result in fines and recoupment of government claims.

In addition, the Corporation is involved in certain legal actions and regulatory investigations arising in the ordinary course of business. At this time, the Corporation is unable to determine the impact of these investigations on its consolidated financial position, results of operations, or liquidity.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

Item 5. Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our only class of common equity is our $0.01 par value common stock, which trades on the NYSE under the symbol PMC. Trading in our common stock commenced on the NYSE on August 1, 2007. Prior to that time, there was no public trading market for our common stock.

The following table sets forth the high and low closing prices per share during the period and the closing price of our common stock as reported by the NYSE for the fiscal periods indicated.

	High	Low	Close
Fiscal 2010			
First Quarter	$ 18.94	$ 16.23	$ 18.22
Second Quarter	$ 20.71	$ 14.49	$ 14.66
Third Quarter	$ 14.36	$ 6.93	$ 9.53
Fourth Quarter	$ 11.83	$ 9.40	$ 11.45
Fiscal 2011			
First Quarter	$ 12.89	$ 10.71	$ 11.44
Second Quarter	$ 13.61	$ 10.61	$ 12.76
Third Quarter	$ 14.73	$ 10.69	$ 14.27
Fourth Quarter	$ 16.40	$ 11.91	$ 15.18

Stockholders

As of January 24, 2012, we had approximately 2,644 stockholders of record of the Corporation s common stock. Because many of our shares of common stock are held by brokers and other institutions on behalf of stockholders, we are unable to estimate the total number of stockholders represented by these record holders.

Cash Dividends

The Corporation has never paid a cash dividend on its common stock and does not expect to pay cash dividends on its common stock in the foreseeable future. Our Senior Secured Credit Facility also limits our ability to declare and pay dividends or other distributions on our shares of common stock. Management believes the stockholders are better served if all of the Corporation s earnings are retained for expansion of the business.

Stock Dividends

On August 25, 2011, the Board of Directors adopted a Rights Plan, providing for the distribution of one right for each share of common stock outstanding. Each right entitles the holder to purchase one one-thousandth (1/1000th) of a share of Series A Junior Preferred Stock, par value $0.01 per share, of the Corporation at a price of $45.00 per one one-thousandth (1/1000th) of a share, subject to adjustment. The rights generally become exercisable at the discretion of the Board of Directors following a public announcement that 15% or more of the Corporation s common stock has been acquired or an intent to acquire has become apparent. The rights will expire on the earlier of August 25, 2021 or redemption by the Corporation. However, the rights will expire immediately at the final adjournment of the Corporation s 2012 annual meeting of stockholders if stockholder approval of the Rights Agreement has not been received prior to that time. Certain terms of the rights are subject to adjustment to prevent dilution. Further description and terms of the rights are set forth in the Rights Agreement.

On August 25, 2011, the Board of Directors declared a dividend of one Right for each outstanding share of common stock. The dividend was paid on September 6, 2011 to the stockholders of record on September 6, 2011.

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Securities authorized for issuance under equity compensation plans

The Corporation has adopted the Amended and Restated PharMerica Corporation 2007 Omnibus Incentive Plan (as amended and restated, Omnibus Plan) under which the Corporation is authorized to grant equity-based and other awards to its employees, officers, directors and consultants. In connection with the Corporation s 2010 Annual Meeting of Stockholders, the stockholders of the Corporation approved and adopted the amended and restated Omnibus Plan to, among other things, implement a fungible share pool effective as of January 1, 2010, and preserve preferential tax treatment as qualified performance-based compensation under Section 162(m) of the Internal Revenue Code.

The Corporation has reserved 7,237,000 shares of its common stock for awards to be granted under the Omnibus Plan plus 534,642 shares issued for substitute equity awards for employees of KPS and PharMerica LTC. Under the fungible share pool, one share of stock will be subtracted from the share limit for each share of stock covered by a stock option or stock appreciation right award and 1.65 shares of stock will be subtracted from the share limit for each share of stock covered by any full-value award, including restricted stock awards, restricted stock units and performance share awards at target. The following shares are not available for re-grant under the Omnibus Plan: (i) shares tendered by a participant or withheld by the Corporation to pay the purchase price of a stock option award or to satisfy taxes owed with respect to an award, (ii) shares subject to a stock appreciation right that are not issued in connection with such award s settlement upon the exercise thereof, and (iii) shares reacquired by the Corporation using cash proceeds received by the Corporation from the exercise of stock options. Effective January 1, 2010, shares subject to an award that is forfeited, expired or settled for cash, are available for re-grant under the Omnibus Plan as one share of stock for each share of stock covered by a stock option or appreciation right and 1.65 shares of stock for each share of stock covered by any other type of award.

The following table sets forth equity compensation plan information as of December 31, 2011:

Plan Category	Number of securities to be issued upon exercise of outstanding options and rights (a)	Weighted-average exercise price of outstanding options and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by stockholders	3,560,500(1)	$ 15.07(2)	3,168,057(3)

(1) Includes the following:

2,744,011 shares of common stock to be issued upon exercise of outstanding stock options granted under the Omnibus Plan;

334,206 shares of common stock to be issued upon vesting of performance share units under the Omnibus Plan;

16,808 shares of common stock to be issued upon vesting of restricted stock awards under the Omnibus Plan; and

465,475 shares of common stock to be issued upon vesting of restricted stock units under the Omnibus Plan.

(2) The weighted average exercise price in column (b) does not take into account the 949,745 shares of common stock potentially to be issued under restricted stock awards, performance share units and restricted stock units.

(3) The 3,168,057 shares does not take into consideration the dilution of 1.65 shares of stock for any full-value award, including restricted stock awards, restricted stock units and performance share units at target. The number of shares remaining available for future issuance calculated under the fungible share pool would be 2,747,573.

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See Note 9 to the Consolidated Financial Statements included in this Report for information regarding the material features of the Omnibus Plan.

On January 18, 2012, a long-term incentive award was granted which was comprised of 299,729 restricted stock units and 199,814 performance share units. The 2012 award reduced the amount of shares available for future issuance calculated under the fungible share pool to 1,923,327.

Stock Performance Graph

The following graph compares the cumulative total return on a $100 investment in each of the Common Stock of the Corporation, the Standard & Poor s 500 Stock Index and the Standard & Poor s Healthcare Index for the period from August 1, 2007 to December 31, 2011. This graph assumes an investment in the Corporation s common stock and the indices of $100 on August 1, 2007 and that all dividends were reinvested:

	PharMerica Corporation	S&P 500	S&P Healthcare
August 1, 2007	$ 100	$ 100	$ 100
September 30, 2007	86	104	104
December 31, 2007	80	100	104
March 31, 2008	96	90	92
June 30, 2008	131	87	90
September 30, 2008	130	79	90
December 31, 2008	91	62	79
March 31, 2009	96	54	72
June 30, 2009	114	63	78
September 30, 2009	108	72	85
December 31, 2009	92	76	92
March 31, 2010	136	80	91
June 30, 2010	106	70	80
September 30, 2010	63	80	87
December 31, 2010	66	86	91
March 31, 2011	66	90	96
June 30, 2011	74	90	103
September 30, 2011	83	77	92
December 31, 2011	88	86	100

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Recent Sales of Unregistered Securities

None.

Purchases of Equity Securities by the Issuer and Affiliated Purchasers

In August 2010, the Board of Directors authorized a share repurchase of up to $25.0 million of the Corporation s common stock.

Share repurchases under this authorization may be made in the open market through unsolicited or solicited privately negotiated transactions, or in such other appropriate manner, and will be funded from available cash. The amount and timing of the repurchases will be determined by the Corporation s management and will depend on a variety of factors including price, corporate and regulatory requirements, capital availability and other market conditions. Common stock acquired through the share repurchase program will be held as treasury shares and may be used for general corporate purposes, including reissuances in connection with acquisitions, employee stock option exercises or other employee stock plans. During the year ended December 31, 2011, the Corporation did not repurchase any shares of its common stock under this program.

Additionally, the Corporation may redeem shares from employees upon vesting of the Corporation s stock awards for minimum statutory tax withholding purposes. The Corporation redeemed 13,311 shares of certain vested awards for an aggregate price of $0.2 million, during the year ended December 31, 2011. These shares have been designated by the Corporation as treasury stock.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2011:

Period	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Program	Approximate Dollar Value of Shares that may yet be Purchased under the Program (in millions)
October 1, 2011 October 31, 2011		$		$ 14.5
November 1, 2011 November 30, 2011	5,189(1)	15.33		14.5
December 1, 2011 December 31, 2011				14.5

(1) The Corporation repurchased 5,189 shares of common stock in connection with the vesting of certain stock awards to cover minimum statutory withholding taxes.

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Item 6. Selected Financial Data

The following table presents our selected historical consolidated financial and operating data. The selected historical financial and operating data should be read in conjunction with, and is qualified in its entirety by reference to, Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and notes thereto included elsewhere in this Annual Report on Form 10-K (in millions, except where indicated):

	Years Ended December 31,				
	2007 (1)	2008	2009	2010	2011
Statement of operations data:					
Revenues	$ 1,217.8	$ 1,947.3	$ 1,841.2	$ 1,847.3	$ 2,081.1
Cost of goods sold	1,044.0	1,660.0	1,565.7	1,607.0	1,787.8
Gross profit	173.8	287.3	275.5	240.3	293.3
Selling, general and administrative	169.3	216.8	190.8	180.6	214.9
Amortization expense	5.0	6.5	9.0	9.3	11.0
Impairment of intangible assets		14.8			5.1
Integration, merger and acquisition related costs and other charges	29.8	26.7	5.2	14.6	15.3
Operating income (loss) (2)	$ (30.3)	$ 22.5	$ 70.5	$ 35.8	$ 47.0
Net income (loss)	$ (24.1)	$ 5.0	$ 42.2	$ 19.2	$ 23.4
Earnings (loss) per common share: (3)					
Basic	$ (1.13)	$ 0.17	$ 1.39	$ 0.64	$ 0.80
Diluted	$ (1.13)	$ 0.17	$ 1.39	$ 0.64	$ 0.79
Adjusted earnings per diluted common share (4)	$ 0.52	$ 1.00	$ 1.30	$ 0.93	$ 1.20
Shares used in computing earnings (loss) per common share:					
Basic	21.3	30.1	30.3	30.0	29.3
Diluted	21.3	30.2	30.4	30.1	29.5
Balance sheet data:					
Cash and cash equivalents	$ 32.0	$ 41.3	$ 51.2	$ 10.8	$ 17.4
Working capital (5)	$ 268.6	$ 272.3	$ 312.8	$ 280.9	$ 349.1
Goodwill (5)	$ 111.3	$ 113.7	$ 140.1	$ 179.4	$ 214.2
Intangible assets, net	$ 77.5	$ 73.4	$ 90.8	$ 102.2	$ 100.2
Total assets	$ 680.1	$ 679.2	$ 724.3	$ 759.7	$ 833.4
Long-term debt	$ 250.0	$ 240.0	$ 240.0	$ 245.6	$ 300.0
Total stockholder s equity	$ 309.2	$ 319.8	$ 370.9	$ 384.4	$ 413.8
Supplemental information:					
Adjusted EBITDA (4)	$ 44.5	$ 92.5	$ 102.7	$ 78.5	$ 98.5
Adjusted EBITDA Margin (4)	3.7%	4.8%	5.6%	4.2%	4.7%
Adjusted EBITDA per prescription dispensed (4)	$ 1.80	$ 2.29	$ 2.63	$ 2.08	$ 2.36
Net cash provided by operating activities	$ 36.3	$ 65.7	$ 85.0	$ 98.2	$ 26.8
Net cash used by investing activities	$ (22.0)	$ (47.4)	$ (76.1)	$ (133.2)	$ (64.0)
Net cash provided by (used in) financing activities	$ 14.0	$ (9.0)	$ 1.0	$ (5.4)	$ 43.8
Statistical information (in whole numbers except where indicated)					
Institutional Pharmacy					
Volume information:					
Prescriptions dispensed (in thousands)	24,751	40,319	39,037	37,826	41,677
Revenue per prescription dispensed	$ 46.99	$ 46.85	$ 45.72	$ 47.31	$ 48.43
Gross profit per prescription dispensed	$ 6.57	$ 6.85	$ 6.84	$ 6.15	$ 6.85
Institutional pharmacy gross margin	14.0%	14.6%	15.0%	13.0%	14.1%
Generic drug dispensing rate	67.4%	70.7%	74.2%	75.5%	77.9%
Customer licensed beds under contract:					
Beginning of period	102,347	336,759	321,062	313,867	362,901
Additions PharMerica Corporation	260,085	21,398	35,921	34,176	27,218
Additions Chem Rx				61,773	3,242
Losses PharMerica Corporation	(25,673)	(37,095)	(43,116)	(46,915)	(44,904)
Losses Chem Rx					(8,959)

End of period	336,759	321,062	313,867	362,901	339,498
Hospital management contracts serviced	86	84	86	90	91

(1) For the year ended December 31, 2007, PharMerica LTC is included beginning August 1, 2007.
(2) Includes depreciation expense of $15.6 million, $22.0 million, $18.0 million, $18.8 million and $20.1 million for the years ended December 31, 2007, 2008, 2009, 2010 and 2011, respectively.
(3) The Corporation has never declared a cash dividend. Earnings (loss) per share in whole dollars and cents.
(4) See Use of Non GAAP Measures for Measuring Annual Results for a definition and Reconciliation of Adjusted Earnings per Diluted Common Share to Earnings Per Diluted Common Share and for Reconciliation of Net Income (loss) to Adjusted EBITDA and Margin.
(5) As adjusted, see Note 2 Acquisitions in the Consolidated Financial Statements

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Use of Non-GAAP Measures For Measuring Annual Results

The Corporation calculates Adjusted EBITDA as provided in the reconciliation below and calculates Adjusted EBITDA Margin by taking Adjusted EBITDA and dividing it by revenues. The Corporation calculates and uses Adjusted EBITDA as an indicator of its ability to generate cash from reported operating results. The measurement is used in concert with net income and cash flows from operating activities, which measure actual cash generated in the period. In addition, the Corporation believes that Adjusted EBITDA and Adjusted EBITDA Margin are supplemental measurement tools used by analysts and investors to help evaluate overall operating performance and the ability to incur and service debt and make capital expenditures. In addition, Adjusted EBITDA, as defined in the Credit Agreement, is used in conjunction with the Corporation s debt leverage ratio and this calculation sets the applicable margin for the quarterly interest charge. Adjusted EBITDA, as defined in the Credit Agreement, is not the same calculation as this Adjusted EBITDA table. Adjusted EBITDA does not represent funds available for the Corporation s discretionary use and is not intended to represent or to be used as a substitute for net income or cash flows from operating activities data as measured under U.S. generally accepted accounting principles (GAAP). The items excluded from Adjusted EBITDA but included in the calculation of the Corporation s reported net income and cash flows from operating activities are significant components of the accompanying consolidated income statements and cash flows, and must be considered in performing a comprehensive assessment of overall financial performance. The Corporation s calculation of Adjusted EBITDA may not be consistent with calculations of EBITDA used by other companies. The following is a reconciliation of the Corporation s net income, net operating cash flows and earnings per diluted share for the periods presented.

The Corporation calculates and uses adjusted earnings per diluted common share, which is exclusive of the impact of impairment of intangible assets, integration, merger and acquisition related costs and other charges, change in estimate on cost of goods sold, change in estimate on allowance for doubtful accounts and tax accounting matters as an indicator of its core operating results. The measurement is used in concert with net income and earnings per diluted share, which measure actual earnings per share generated in the period. The Corporation believes the exclusion of these charges in expressing earnings per share provides management with a useful measure to assess period to period comparability and is useful to investors in evaluating the Corporation s operating results from period to period. Adjusted earnings per diluted common share, which is exclusive of the impact of impairment of intangible assets, integration, merger and acquisition related costs and other charges, change in estimate on cost of goods sold, change in estimate on allowance for doubtful accounts and tax accounting matters does not represent the amount that effectively accrues directly to stockholders (i.e., such costs are a reduction in earnings and stockholders equity) and is not intended to represent or to be used as a substitute for earnings per diluted share as measured under GAAP. The integration, merger and acquisition related costs and other charges, impairment on intangible assets, change in estimate on cost of goods sold, change in estimate on allowance for doubtful accounts and tax accounting matters excluded from the earnings per diluted share are significant components of the accompanying consolidated income statements, and must be considered in performing a comprehensive assessment of overall financial performance.

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Reconciliation of Net Income (Loss) to Adjusted EBITDA

	$44.5	$44.5	$44.5	$44.5	$44.5
	Years Ended December 31,				
	2007	2008	2009	2010	2011
Net income (loss)	$ (24.1)	$ 5.0	$ 42.2	$ 19.2	$ 23.4
Add:					
Interest expense, net	7.2	14.2	9.4	3.6	8.8
Integration, merger and acquisition related costs and other charges	29.8	26.7	5.2	14.6	15.3
Provision (benefit) for income taxes	(13.4)	3.3	18.9	13.0	14.8
Effect of change in estimate on cost of goods sold	(3.1)				
Effect of change in estimate on allowance for doubtful accounts	27.9				
Impairment of intangible assets		14.8			5.1
Depreciation and amortization expense	20.2	28.5	27.0	28.1	31.1
Adjusted EBITDA	$ 44.5	$ 92.5	$ 102.7	$ 78.5	$ 98.5
Adjusted EBITDA Margin	3.7%	4.8%	5.6%	4.2%	4.7%

Reconciliation of Adjusted EBITDA to Net Operating Cash Flows

	Years Ended December 31,				
	2007	2008	2009	2010	2011
Adjusted EBITDA	$ 44.5	$ 92.5	$ 102.7	$ 78.5	$ 98.5
Interest expense, net	(7.2)	(14.2)	(9.4)	(3.6)	(8.8)
(Provision) benefit for income taxes	13.4	(3.3)	(18.9)	(13.0)	(14.8)
Effect of change in estimate on cost of goods sold	3.1				
Effect of change in estimate on allowance for doubtful accounts	(27.9)				
Integration, merger and acquisition related costs and other charges	(22.6)	(22.2)	(4.8)	(14.0)	(13.8)
Provision for bad debt	44.1	24.7	16.6	18.5	24.8
Stock-based compensation	1.5	4.9	4.6	4.8	5.9
Amortization of deferred financing fees	0.2	0.4	0.4	0.6	0.8
Loss on disposition of equipment	0.1	0.2	0.3	0.3	0.1
Deferred income taxes	(13.4)	2.8	19.7	12.3	13.9
Other	(0.9)	(0.5)	(0.3)		0.2
Changes in assets and liabilities	1.4	(19.6)	(25.9)	13.8	(80.0)
Net Cash Flows from Operating Activities	$ 36.3	$ 65.7	$ 85.0	$ 98.2	$ 26.8

Reconciliation of Earnings Per Diluted Common Share to Adjusted Earnings Per Diluted Common Share

	Years Ended December 31,				
	2007	2008	2009	2010	2011
Earnings (loss) per diluted common share	$ (1.13)	$ 0.17	$ 1.39	$ 0.64	$ 0.79
Add:					
Diluted earnings per share impact of:					
Impairment of intangible assets		0.30			0.11
Integration, merger, and acquisition related costs and other charges	0.90	0.53	0.10	0.29	0.32

Effect of change in estimate on cost of goods sold	(0.09)				
Effect of change in estimate on allowance for doubtful accounts	0.84				
Tax accounting matters			(0.19)		(0.02)
Adjusted earnings per diluted common share after impact of above items	$ 0.52	$ 1.00	$ 1.30	$ 0.93	$ 1.20

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Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements, within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended, which reflect the Corporation s current estimates, expectations and projections about the Corporation s future results, performance, prospects and opportunities. Forward looking statements include, among other things, the information concerning the Corporation s possible future results of operations including revenue, costs of goods sold, and gross margin, business and growth strategies, financing plans, the Corporation s competitive position and the effects of competition, the projected growth of the industries in which we operate, and the Corporation s ability to consummate strategic acquisitions. Forward-looking statements include statements that are not historical facts and can be identified by forward-looking words such as anticipate, believe, could, estimate, expect, intend, plan, may, should, will, would, project, and similar expressions. These forward-looking statements are based upon i currently available to the Corporation and are subject to a number of risks, uncertainties and other factors that could cause the Corporation s actual results, performance, prospects or opportunities to differ materially from those expressed in, or implied by, these forward-looking statements. Important factors that could cause the Corporation s actual results to differ materially from the results referred to in the forward-looking statements the Corporation makes in this report include:

the impact of Omnicare s unsolicited tender offer to acquire all of our outstanding common stock, including distracting attention of employees, requiring expenditure of substantial time and resources, disrupting our business activities, and increasing the volatility of our stock price;

the impact of the litigation by Omnicare and other stockholders relating to Omnicare s unsolicited tender offer;

the Corporation s access to capital, credit ratings, indebtedness, and ability to raise additional financings and operate under the terms of the Corporation s debt obligations;

anti-takeover provisions of the Delaware General Corporation Law, which in concert with our certificate of incorporation and our by-laws could delay or deter a change in control;

certain restrictions resulting from continuing relationships with the Corporation s former parent company;

the effects of adverse economic trends or intense competition in the markets in which we operate;

the demand for the Corporation s products and services;

the effects of retaining existing customers and service contracts and the Corporation s ability to attract new customers for growth of the Corporation s business;

the effects of renegotiating contract pricing relating to significant customers and suppliers, including the hospital pharmacy segment which is substantially dependent on service provided to one customer;

the effects of an increase in credit risk, loss or bankruptcy of or default by any significant customer, supplier, or other entity relevant to the Corporation s operations;

the Corporation s ability to successfully pursue the Corporation s development and acquisition activities and successfully integrate new operations and systems, including the realization of anticipated revenues, economies of scale, cost savings, and productivity gains associated with such operations;

the Corporation s ability to control costs, particularly labor and employee benefit costs, rising pharmaceutical costs, and regulatory compliance costs;

the effects of healthcare reform and government regulations, including, interpretation of regulations and changes in the nature and enforcement of regulations governing the healthcare and institutional pharmacy services industries;

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changes in the reimbursement rates or methods of payment from Medicare and Medicaid and other third party payers to both us and our customers;

the potential impact of state government budget shortfalls and their ability to pay the Corporation and its customers for services provided;

the Corporation s ability, and the ability of the Corporation s customers, to comply with Medicare or Medicaid reimbursement regulations or other applicable laws;

the effects of changes in the interest rate on the Corporation s outstanding floating rate debt instrument and the increases in interest expense, including increases in interest rate terms on any new debt financing;

the Corporation s ability to implement the short cycle dispensing requirements of the 2010 Health Care Legislation without incurring significant additional operating costs;

further consolidation of managed care organizations and other third party payers;

political and economic conditions nationally, regionally, and in the markets in which the Corporation operates;

natural disasters, war, civil unrest, terrorism, fire, floods, tornadoes, earthquakes, hurricanes, epidemic, pandemic, catastrophic event or other matters beyond the Corporation s control;

increases in energy costs, including state and federal taxes, and the impact on the costs of delivery expenses and utility expenses;

elimination of, changes in, or the Corporation s failure to satisfy pharmaceutical manufacturers rebate programs;

the Corporation s ability to attract and retain key executives, pharmacists, and other healthcare personnel;

the Corporation s risk of loss not covered by insurance;

the outcome of litigation to which the Corporation is a party from time to time, including adverse results in material litigation or governmental inquiries;

changes in accounting rules and standards, audits, compliance with the Sarbanes-Oxley Act, and regulatory investigations;

changes in market conditions that would result in the impairment of goodwill or other assets of the Corporation;

changes in market conditions in which we operate that would influence the value of the Corporation s stock;

changes in volatility of the Corporation s stock price and the risk of litigation following a decline in the price of the Corporation s stock price;

the Corporation s ability to anticipate a shift in demand for generic drug equivalents and the impact on the financial results including the negative impact on brand drug rebates;

prescription volumes may decline, and our net revenues and profitability may be negatively impacted, if the safety risk profiles of drugs increase or if drugs are withdrawn from the market, including as a result of manufacturing issues, or if prescription drugs transition to over-the-counter products;

the effects on the Corporation s results of operations related to interpretations of accounting principles by the SEC staff that may differ from those of management;

changes in tax laws and regulations;

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the effects of changes to critical accounting estimates; and

other factors, risks and uncertainties referenced in the Corporation s filings with the Commission, including the Risk Factors set forth in this Report on Form 10-K for the year ended December 31, 2011.

YOU ARE CAUTIONED NOT TO PLACE UNDUE RELIANCE ON ANY FORWARD-LOOKING STATEMENTS, ALL OF WHICH SPEAK ONLY AS OF THE DATE OF THIS ANNUAL REPORT. EXCEPT AS REQUIRED BY LAW, WE UNDERTAKE NO OBLIGATION TO PUBLICLY UPDATE OR RELEASE ANY REVISIONS TO THESE FORWARD-LOOKING STATEMENTS TO REFLECT ANY EVENTS OR CIRCUMSTANCES AFTER THE DATE OF THIS ANNUAL REPORT OR TO REFLECT THE OCCURRENCE OF UNANTICIPATED EVENTS. ALL SUBSEQUENT WRITTEN AND ORAL FORWARD-LOOKING STATEMENTS ATTRIBUTABLE TO US OR ANY PERSON ACTING ON THE CORPORATION S BEHALF ARE EXPRESSLY QUALIFIED IN THEIR ENTIRETY BY THE CAUTIONARY STATEMENTS CONTAINED OR REFERRED TO IN THIS SECTION AND IN OUR RISK FACTORS SET FORTH IN PART I, ITEM 1A OF THIS REPORT ON FORM 10-K AND IN OTHER REPORTS FILED WITH THE SEC BY THE CORPORATION.

The Corporation s Business and Industry Trends

The Corporation is an institutional pharmacy services company, which services healthcare facilities and provides management pharmacy services to hospitals. The Corporation is the second largest institutional pharmacy services company in the United States. The Corporation operates 95 institutional pharmacies in 44 states. The Corporation s customers are typically institutional healthcare providers, such as nursing centers, assisted living facilities, hospitals and other long-term alternative care settings. The Corporation is generally the primary source of supply of pharmaceuticals to its customers. The Corporation also provides pharmacy management services to 91 hospitals in the United States.

The institutional pharmacy services business is highly competitive. Competition is a significant factor that can impact the Corporation s overall financial results, pricing to customers, and bed retention. In each geographic market, there are national, regional and local institutional pharmacies that provide services comparable to those offered by the Corporation s pharmacies. These pharmacies may have greater financial and other resources than we do and may be more established in the markets they serve than we are. The Corporation also competes against regional and local pharmacies that specialize in the highly-fragmented long-term care markets. In the future some of the Corporation s customers may seek to in-source the provision of pharmaceuticals to patients in their facilities by establishing an internal pharmacy.

A variety of factors are affecting the institutional pharmacy industry. With an aging population and the extension of drug coverage to a greater number of individuals through Medicare Part D, the consumption of pharmaceuticals by residents of long-term care facilities is likely to increase in the future. In addition, individuals are expected to enter assisted living facilities, independent living facilities and continuing care retirement communities at increasing rates. Under Medicare Part D, eligible individuals may choose to enroll in various Medicare Part D Plans to receive prescription drug coverage. Each Medicare Part D Plan determines a distinct formulary for the long-term care residents enrolled in its plan. Accordingly, institutional pharmacies have incurred increased administrative costs to manage each Part D Plan s formulary, reimbursement and administrative processes for their long-term care enrollees. Institutional pharmacies may continue to experience increased administrative burdens and costs due to the greater complexity of the requirements for drug reimbursement, including costs associated with the short cycle dispensing requirements which take effect January 1, 2013. Medicare Part D also requires increased choices for patients with respect to complex drug categories and therapeutic interchange opportunities. Institutional pharmacies may realize increased revenue by providing long-term care residents with specialized services in these areas. Continued industry consolidation may also impact the dynamics of the institutional pharmacy market.

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In addition, our continued success depends on our ability to attract and retain pharmacists and other pharmacy professionals. Competition for qualified pharmacists and other pharmacy professionals is strong. The loss of pharmacy personnel or the inability to attract, retain or motivate sufficient numbers of qualified pharmacy professionals could adversely affect our business. Although we generally have been able to meet our staffing requirements for pharmacists and other pharmacy professionals in the past, our inability to do so in the future could have a material adverse impact on us.

Unsolicited Tender Offer by Omnicare

On August 23, 2011, Omnicare, Inc. (Omnicare) made public an unsolicited proposal to acquire all of the outstanding shares of the Corporation s common stock for $15.00 per share in cash. After careful consideration with our financial and legal advisors, our Board of Directors determined unanimously that Omnicare s proposal undervalues the Corporation and was not in the best interests of our stockholders. On September 7, 2011, Omnicare, through its wholly-owned subsidiary, Philadelphia Acquisition Sub, Inc., commenced an unsolicited tender offer to purchase all of the outstanding shares of our common stock at $15.00 per share. On September 18, 2011, the Board again met with its financial and legal advisors, and after careful consideration our Board of Directors again unanimously recommended that our stockholders reject the offer and not tender their shares of our common stock because it believes that Omnicare s tender offer (i) undervalues the Corporation and its prospects, (ii) is illusory because it is subject to significant regulatory and other uncertainty, and (iii) is opportunistic based on the Corporation s then traded market value. On September 20, 2011, we filed with the Securities and Exchange Commission (SEC) a Recommendation/Solicitation Statement on Schedule 14D-9 detailing the recommendation of our Board of Directors in response to Omnicare s tender offer and the reasons it rejected the offer. See Note 6 Commitments and Contingencies for a discussion of certain litigation commenced in respect of Omnicare s tender offer and related actions. On October 5, 2011, Omnicare extended the expiration date of its tender offer until 5:00 p.m., New York City time, on Friday, December 2, 2011, unless further extended. On December 5, 2011, Omnicare extended the expiration date of its tender offer until 5:00 p.m., New York City time, on Friday, January 20, 2012, unless further extended. On January 19, 2012, Omnicare extended the expiration date of its tender offer until 5:00 p.m., New York time, on Friday, January 27, 2012, unless further extended. On January 27, 2012, Omnicare extended the expiration of its tender offer until 5:00 p.m., New York City time, on Friday, February 17, 2012, unless further extended.

On August 25, 2011, after careful consideration and consultation with our financial and legal advisors, our Board of Directors adopted a rights plan and authorized the execution of the Rights Agreement, dated August 25, 2011 (the Rights Agreement), between the Corporation and Mellon Investor Services LLC, as Rights Agent. On August 25, 2011, the Board of Directors of the Corporation declared a dividend of one preferred share purchase right (a Right) for each outstanding share of common stock, par value $0.01 per share. The dividend was payable on September 6, 2011 to the stockholders of record on September 6, 2011. The Rights will expire on the earlier of August 25, 2021, or redemption by the Corporation. However, the rights will expire immediately at the final adjournment of the Corporation s 2012 annual meeting of stockholders if stockholder approval of the Rights Agreement has not been received prior to that time. The Rights Agreement is designed to prevent third parties from opportunistically acquiring the Corporation in a transaction that the Corporation s Board of Directors believes is not in the best interests of the Corporation s stockholders. In general terms, it works by imposing a significant penalty upon any person or group that acquires beneficial ownership of 15 percent or more of our outstanding common stock without the prior approval of our Board of Directors. The Corporation s Board of Directors believes the Rights Agreement has helped the Corporation s stockholders at this time by effectively preventing Omnicare from opportunistically acquiring the Corporation at a price that the Corporation s Board of Directors believes is inadequate for the reasons discussed above. The Rights Agreement has been narrowly tailored in a manner that our Board of Directors believes appropriately balances the interests of our stockholders in connection with what our Board of Directors considers an opportunistic, illusory and disadvantageous proposal, against the need to avoid excessive anti-takeover protections that ultimately may adversely impact stockholder value. The Rights Agreement should not interfere with any merger or other business combination approved by the Board of Directors.

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Pursuant to the requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the regulations thereunder (the HSR Act), Omnicare filed a Notification and Report Form with the Antitrust Division of the U.S. Department of Justice (the Antitrust Division) and the Federal Trade Commission (the FTC) relating to its proposed acquisition of the Corporation on September 7, 2011. On or about September 19, 2011, the Corporation submitted a responsive Notification and Report Form with the Antitrust Division and the FTC. On September 22, 2011, the Corporation received a request for additional information from the FTC relating to the tender offer. On September 22, 2011, Omnicare also received a request for additional information from the FTC relating to the tender offer (the Second Request). The Second Request extended the waiting period under the HSR Act for 10 calendar days after the date Omnicare certified substantial compliance with the Second Request issued to Omnicare. On September 30, 2011, the FTC also issued a subpoena and civil investigative demand to the Corporation covering the same subject matter as the Second Request. The Corporation has produced a considerable amount of material in response to the FTC requests.

On November 18, 2011 Omnicare certified to the FTC that it had substantially complied with the Second Request. On November 18, 2011, Omnicare also executed a timing agreement with the FTC pursuant to which Omnicare agreed (i) to provide 14 days notice to the FTC prior to consummating its proposed acquisition and (ii) not to consummate its proposed acquisition prior to December 19, 2011 without the consent of the FTC. On December 2, 2011, Omnicare agreed with the FTC to extend the date prior to which Omnicare will not consummate its proposed acquisition to January 19, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 10, 2012, Omnicare agreed with the FTC that it will not consummate its proposed acquisition prior to January 26, 2012, unless the FTC notifies Omnicare that it has closed its investigation relating to its proposed acquisition. On January 27, 2012, the FTC issued an administrative complaint to block Omnicare s proposed acquisition of the Corporation. The complaint alleges that the proposed acquisition would be illegal and in violation of Section 15 of the FTC Act and Section 7 of the Clayton Act because it would harm competition and enable Omnicare to raise the price of drugs for Medicare Part D consumers and others. The case is scheduled to be heard before an administrative law judge at the FTC in June 2012.

The financial and outside legal advisors to the Corporation and Omnicare have continued to meet from time to time in an effort to agree upon an acceptable information sharing process relating to antitrust issues. On October 26, 2011, the Corporation and Omnicare and their respective outside legal advisors entered into a Confidentiality and Joint Defense Agreement (the Confidentiality and Joint Defense Agreement), which provides, among other things, for the parties to exchange on a confidential and privileged basis information in order to facilitate their respective assessment of the antitrust risk associated with a potential combination of the two companies. Although the Corporation s Board of Directors continues to believe that Omnicare s $15.00 per share offer undervalues the Corporation, the Corporation is engaging in this analytical process in order to further its understanding of Omnicare s assessment of the antitrust risk related to a business combination. The Confidentiality and Joint Defense Agreement does not obligate the Corporation to enter a transaction with Omnicare and there can be no assurance that this review will lead to a definitive merger agreement or any transaction between the two companies.

In connection with these matters, for the year ended December 31, 2011, we expensed $2.8 million of legal and advisory fees, which are included in integration, merger and acquisition related costs and other charges in the consolidated financial statements. We expect to incur significant additional costs in the future in connection with Omnicare s unsolicited tender offer.

Acquisitions During the Periods Presented

For a discussion of Acquisitions by the Corporation during the periods presented see Note 2 Acquisitions to our Consolidated Financial Statements included elsewhere in this Report.

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Critical Accounting Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the U.S. requires us to make estimates and assumptions that affect reported amounts and related disclosures. Management considers an accounting estimate to be critical if:

- It requires assumptions to be made that were uncertain at the time the estimate was made; and
- Changes in the estimate or different estimates could have a material impact on our consolidated results of operations or financial condition.

The Corporation s management has discussed the development and selection of these critical accounting estimates with the audit committee of the Board of Directors and with the Corporation s independent registered public accounting firm, and they both have reviewed the disclosure presented below relating to critical accounting estimates.

The table of critical accounting estimates is not intended to be a comprehensive list of all of the Corporation s accounting policies that require estimates. Management believes that of the significant accounting policies, as discussed in Note 1 of the consolidated financial statements included elsewhere in this report, the estimates discussed below involve a higher degree of judgment and complexity. Management believes the current assumptions and other considerations used to estimate amounts reflected in the consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in the consolidated financial statements, the resulting changes could have a material adverse effect on the consolidated results of operations and financial condition of the Corporation.

The table that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate. Our sensitivity analysis was performed assuming the assumptions listed, based upon the actual results of the Corporation for the year ended December 31, 2011, and the actual diluted shares.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Allowance for doubtful accounts and provision for doubtful accounts

Accounts receivable primarily consist of amounts due from Prescription Drug Plans (PDP s) under Medicaid Part D, long-term care institutions, the respective state Medicaid programs, private payers and third party insurance companies. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. We establish an allowance for doubtful accounts to reduce the carrying value of our receivables to their estimated net realizable value. In addition, certain drugs dispensed are subject to being returned and the responsible paying party is due a credit for such returns.

Our allowance for doubtful accounts, included in our balance sheets at December 31, 2010 and 2011, were $36.8 million and $48.6 million, respectively.

Our quarterly provision for doubtful accounts included in our income statements was as follows (dollars in millions):

	Amount	% of Revenues
2009		
March 31	$ 7.1	1.5%
June 30	3.6	0.8
September 30	2.5	0.5
December 31	3.4	0.8
2010		
March 31	$ 3.8	0.8%
June 30	4.6	1.0
September 30	4.5	1.0
December 31	5.6	1.1
2011		
March 31	$ 5.4	1.0%
June 30	5.8	1.1
September 30	6.4	1.2
December 31	7.2	1.5

Assumptions/Approach Used

The largest components of bad debts in our accounts receivable relate to the accounts for which private payers are responsible (which we refer to as private and other), accounts for which our customers from long-term care institutions are responsible for under Medicare Part A and owe us for the drug component of their patients stay at their respective institution and third party, Medicare Part D, and Medicaid accounts that have been denied.

We attempt to collect the private and other accounts through various efforts for which the patient is the responsible party. We attempt to collect payments due from long-term care institutions through billing and collecting in accordance with the terms of the contracts. We attempt to collect from third party, Medicare Part D and Medicaid accounts by obtaining the appropriate documentation and direct discussions with the payors. In all cases, the drugs have been dispensed.

In general, we perform the following steps in collecting accounts receivable:

if possible, perform up front adjudication prior to dispensing the product;

billing and follow-up with third party payers;

billing and follow-up with long-term care institutions;

utilization of collection agencies; and

other legal processes.

The Corporation has an established process to determine the adequacy of the allowance for doubtful accounts, which relies on analytical tools, specific identification, and benchmarks to arrive at a reasonable allowance. No single statistic or measurement alone determines the allowance for doubtful accounts.

We monitor and review trends by payer classification along with the composition of our aging accounts receivable. This review is focused primarily on trends in private and other payer, PDP s, dual eligible co-payments, historic payment patterns of long-term care institutions, and monitoring respective credit risks.

In addition, we analyze other factors such as revenue days in accounts receivables, denial trends by payer types, payment patterns by payer types, subsequent cash collections, and current events that may impact payment patterns of our long-term care institution customers.

The following table shows our institutional pharmacy revenue days outstanding reflected in our institutional pharmacy net accounts receivable as of the dates indicated:

	2009	2010	2011
March 31	42.4	40.5	39.0
June 30	42.0	40.4	41.6
September 30	42.1	40.3	42.5
December 31	42.9	39.7	42.8

In the first quarter of 2010, the Corporation benefited from improved collections from the Part D payors due to the requirements of the MIPPA. MIPPA required Part D payors to pay claims within 30 days, or within 14 days if submitted electronically, beginning with the 2010 plan years. As a result of the MIPPA requirements, the Corporation collected a larger amount of receivables in the first quarter of 2010 than normal.

Sensitivity Analysis

If our provision as a percent of institutional revenue increases 0.10%, our after tax income would decrease by approximately $1.2 million or $0.04 per diluted share.

This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate uncollectible accounts that are highly uncertain and requires a high degree of judgment. Our estimates may be impacted by economic conditions, success in collections, payer mix and trends in federal and state regulations.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Allowance for doubtful accounts and provision for doubtful accounts -(continued)

The following table shows our allowance for doubtful accounts as a percent of gross accounts receivable:

	Allowance	Gross Accounts Receivable	% of Gross Accounts Receivable
2009			
March 31	$ 49.1	$ 267.8	18.3%
June 30	50.4	260.6	19.3
September 30	46.3	261.6	17.7
December 31	40.2	255.5	15.7
2010			
March 31	$ 37.6	$ 241.8	15.6%
June 30	37.1	237.6	15.6
September 30	38.1	231.9	16.4
December 31	36.8	263.3	14.0
2011			
March 31	$ 38.1	$ 273.9	13.9%
June 30	39.6	282.4	14.0
September 30	42.9	282.8	15.2
December 31	48.6	281.0	17.3

Please refer to Note 1 to our consolidated financial statements included elsewhere in this report for a detailed rollforward of our allowance for doubtful accounts.

The allowance for doubtful accounts for 2009 included a transfer of reserves on contractual adjustments into the allowance for doubtful accounts during the period. The reclassification did not impact the provision for bad debt.

Assumptions/Approach Used

The following table shows our summarized aging categories by quarter: