PharMerica CORP
Form 10-K
February 07, 2013
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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, 2012

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	**40299**
(Address of Principal Executive Offices)	**(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. þ

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, 2012 was $313,006,610.

Class of Common Stock	Outstanding at February 1, 2013
Common stock, $0.01 par value	29,541,976 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 2013 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, 2012.

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PHARMERICA CORPORATION

FORM 10-K

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Part I

Item 1. Business

Overview

Formed in 2006, PharMerica Corporation (the Corporation, we, us, or our), a Delaware Corporation, is an institutional pharmacy services company that services healthcare facilities, provides pharmacy management services to hospitals and also provides specialty infusion services to patients outside a hospital setting. The Corporation is the second largest institutional pharmacy services company in the United States based on revenues and customer licensed beds under contract, operating 91 institutional pharmacies and 12 specialty infusion pharmacies in 45 states. The Corporation s customers are typically institutional healthcare providers, such as skilled nursing facilities, nursing centers, assisted living facilities, hospitals, individuals receiving in-home care 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 89 hospitals in the United States.

Institutional Pharmacy Business

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. We provide 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 14 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. The Corporation also utilizes an on-site dispensing system, with real time data transfer between the system and the Corporation, which provides timely medication administration in emergency and first dose situations. 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.

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

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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.

We provide consultant pharmacist services to approximately 70% 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 efficiency 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.

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 Participation for Long Term Care Facilities (the Proposed Rule). 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. After reviewing the comments, CMS declined to finalize the portion of the Proposed Rule requiring the independence of consultant pharmacists from LTC pharmacies. CMS further noted that the independent consultant pharmacist requirement would be highly disruptive to both LTC facilities and consultant pharmacists, and without additional regulation of facility staff and providers, any benefits would not outweigh the costs of industry disruption. However, CMS solicited additional comments and acknowledged the possibility of future regulations if there fails to be improvement in inappropriate utilization throughout the industry. The Corporation believes that a future 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 future regulations in consultant pharmacist services.

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;

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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 (IV) drug therapy products and services to its customers. We provide IV products and services to client facilities as well as hospice and home care patients.

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, we arrange for consultants to 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.

Specialty Infusion Services

The Corporation provides specialty infusion services focused on providing complex pharmaceutical products and clinical services to patients outside of hospital or nursing home settings. We offer high-touch clinical services to patients with acute or chronic conditions. The delivery of home infusion therapy requires comprehensive planning and monitoring which is provided through our registered nursing staff. Our nursing staff performs an initial patient assessment, provides therapy specific training and education, administers therapy and monitors for potential side effects. We also provide extensive clinical monitoring and patient follow-up to ensure adherence and proactively manage patients conditions. An in-network strategy facilitates easier decision-making for referral sources and provides us with the ability to pre-authorize patients, auto adjudicate, and bill electronically, enabling faster prescription turnaround.

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 Healthcare, Inc. (Kindred) hospitals.

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 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.

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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 45 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 in 2007, the Corporation has acquired eight institutional pharmacy businesses and one specialty infusion services business.

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 and other long-term alternative care settings. We are generally the primary source 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.

At December 31, 2012, we had contracts to provide pharmacy services to 307,008 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, 2012, revenues from Kindred s nursing facilities represented approximately 11.5% of the Corporation s total revenues.

Specialty Infusion Services. At December 31, 2012, the Corporation provided specialty infusion services to patients in 14 states with acute or chronic conditions in a setting outside of a hospital or nursing home.

Hospital Pharmacy Management Services. At December 31, 2012, the Corporation provided hospital pharmacy management services to Kindred and other customers at 89 locations. For the year ended December 31, 2012, revenues under the Kindred hospital pharmacy management service contracts represented approximately 3.4% of the Corporation s total revenues.

Suppliers/Inventory

Effective January 1, 2011, the Corporation entered into an Amended and Restated Prime Vendor Agreement for Long-Term Care Pharmacies (the Amended Prime Vendor Agreement) by and between ABDC, a wholly owned subsidiary of AmerisourceBergen Corporation, the Corporation, Pharmacy Corporation of America and Chem Rx Pharmacy Services, LLC. On January 25, 2013 the Corporation renegotiated its Amended Prime Vendor Agreement with AmerisourceBergen effective January 1, 2013. The First Amendment to the Amended Prime Vendor Agreement (the First Amendment) modifies the previous agreement, which was set to expire September 30, 2013 and extends its term until September 30, 2016.

The First Amendment requires the Corporation to purchase certain levels of brand and non-injectable generic drugs from ABDC. The First Amendment does provide the flexibility for the Corporation to contract with other suppliers. If the Corporation fails to adhere to the contractual purchase provisions ABDC has the ability to increase the Corporation s drug pricing under the terms of the First Amendment.

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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.

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 Corporation s generic drug dispensing rate:

2010	2011	2012
76.5%	79.6%	83.3%

The following table summarizes the material brand-to-generic conversions expected to occur in 2013 through 2017:

2013	2014	2015	2016	2017
Diovan (1Q)	Detrol LA (1Q)	Namenda (1Q)	Crestor (3Q)	Seroquel XR (3Q)
Humalog (2Q)	Invega Sustenna (1Q)	Risperdal Consta (1Q)		
Oxycotin (2Q)	Renvela (1Q)	Abilify (2Q)		
Lidoderm Patch (3Q)	Trilipix (1Q)	Aggrenox (3Q)		
Cymbalta (4Q)	Celebrex (2Q)	Invanz (4Q)		
	Copaxone (2Q)			
	Zyvox (2Q)			
	Nexium (2Q)			
	Lumigan 0.03% (3Q)			

(Number in parentheses refers to 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. In addition, the number of generic manufacturers entering the market impacts the overall cost and reimbursement of generic drugs. This acceleration in the reimbursement reduction and the number of generic manufacturers have 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 the Corporation s 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.

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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.

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, private payers, 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, institutional healthcare providers, and Medicaid, will affect our profitability.

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

	2010		2011		2012	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare Part D	$ 859.5	46.5%	$ 998.1	48.0%	$ 873.0	47.6%
Institutional healthcare providers	555.8	30.1	616.2	29.6	561.4	30.6
Medicaid	169.6	9.2	217.2	10.4	165.9	9.1
Private and other	107.3	5.8	92.7	4.5	84.7	4.6
Insured	89.8	4.9	90.0	4.3	79.5	4.3
Medicare	7.4	0.4	4.4	0.2	4.2	0.3
Hospital management fees	57.9	3.1	62.5	3.0	63.9	3.5
Total	$ 1,847.3	100.0%	$ 2,081.1	100.0%	$ 1,832.6	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.

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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 institutional pharmacy services 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, however seasonality does not have a material effect on the Corporation s financial results.

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 .

Employees

As of December 31, 2012, we had approximately 6,100 employees which included approximately 1,100 part-time employees. The Corporation had approximately 500 employees that were covered by collective bargaining agreements as of December 31, 2012. These agreements expire on December 31, 2013. As of December 31, 2012, we employed approximately 1,600 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 laws.

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.

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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.

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 that 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.

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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 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 condition, 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

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reasonably anticipated threats or hazards to the security of such information and the unauthorized use or disclosure of such information.

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 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 Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, 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 unpermitted disclosures of PHI. A final rule was submitted by the Secretary in 2010, but later withdrawn. The final rule was issued on January 17, 2013.

2010 Health Care Reform Legislation

The Patient Protection and Affordable Care Act and the reconciliation law known as Health Care and Education Affordability Reconciliation Act (combined we refer to both Acts as the 2010 Health Care Reform Legislation) were enacted in March 2010. State participation in the expansion of Medicaid under the 2010 Health Care Reform Legislation is voluntary. Three key provisions of the 2010 Health Care Reform 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 Medicare Part D coverage gap, which is otherwise known as the Donut Hole, and (iii) short cycle dispensing. Regulations under the 2010 Health Care Reform Legislation are expected to continue being drafted, released, and finalized throughout the next several years. Pending the promulgation of these regulations, the Corporation is unable to fully evaluate the impact of the 2010 Health Care Reform Legislation.

FUL and AMP Changes

The 2010 Health Care Reform Legislation amended the Deficit Reduction Act of 2005 (the DRA) to change the definition of the Federal Upper Limit (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 Reform 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

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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 FULs as a result of the new volume-weighted requirements pursuant to the 2010 Health Care Reform 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 Medicare 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 Reform Legislation requires Medicare to close or eliminate the coverage gap entirely by fiscal year 2020 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 Reform Legislation, Prescription Drug Plans (PDPs) are 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 Medicare 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. Pursuant to CMS issued regulation, beginning January 1, 2013, pharmacies dispensing to long-term care facilities must dispense no more than 14-day supplies of brand-name oral solid medications covered by Medicare Part D. The Corporation fully implemented short cycle dispensing on January 1, 2013. The impact of short cycle dispensing is not expected to have a material adverse impact on the Corporation s results of operations.

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

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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) Medicare Part C or Medicare Advantage, a managed care option for beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, 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, oxygen equipment, hospital beds, walkers, negative pressure wound therapy pumps and supplies are among the 10 categories of DMEPOS included in the first round of the competitive bidding process. The Corporation submitted bids in all geographic areas for the enteral nutrient category prior to the March 3, 2012 deadline set by CMS. Once the bidding and selection process is completed, proposed implementation of the contracts and pricing will be July 2013. Medicare Part B is not material to the Corporation, representing 0.3% of revenues.

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

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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.

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 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 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.

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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.

Failed 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. On January 27, 2012 the Federal Trade Commission (FTC) issued an administrative complaint to block Omnicare s proposed acquisition of the Corporation. The complaint alleged 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. On February 21, 2012 the unsolicited tender offer expired and Omnicare did not extend the offer.

In connection with these matters, in the years ended December 31, 2011 and 2012 we expensed $2.8 million and $1.9 million, respectively, of legal and advisory fees, which are included in merger, acquisition, integration costs and other charges in the consolidated income statements. The Corporation does not expect to incur any additional costs in the future in connection with Omnicare s unsolicited tender offer.

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 Securities and Exchange Commission (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 condition and stock price.

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 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, including prior and current customers, 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 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.

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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.

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.

Home infusion joint ventures formed with hospitals could adversely affect our financial results.

The home infusion industry is currently seeing renewed activity in the formation of equity-based infusion joint ventures formed with hospitals. This activity stems, in part, from hospitals seeking to position themselves for new paradigms in the delivery of coordinated healthcare and new methods of payment, including an emerging interdisciplinary care model that is being labeled an accountable care organization . These organizations are encouraged by the 2010 Health Care Reform Legislation. These entities are being designed in order to save money and improve quality of care by better integrating care, with the healthcare provider possibly sharing in the financial benefits of the improved efficiency.

Participation in equity-based joint ventures offers hospitals and other providers an opportunity to more efficiently transfer patients to less expensive care settings, while keeping the patient within its network. Additionally, it provides many hospitals with a mechanism to invest accumulated profits in a growing sector with attractive margins.

If home infusion joint ventures continue to expand and we lose referrals as a result, our financial condition, results of operations and liquidity could be adversely affected.

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 revenues 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 and the number of generic manufacturers have resulted in margin compression as multi-source alternatives have become available much earlier than we have historically experienced. In addition, the number of generic manufacturers entering the market impacts the overall cost and reimbursement of generic drugs. 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

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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.

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.

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

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 condition, results of operations and liquidity.

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Changes in Medicaid reimbursement may reduce our revenue.

The 2010 Health Care Reform Legislation amended 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 Reform 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 Reform 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 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.

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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 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, 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 condition, 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.

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 condition, results of operations, and liquidity.

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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 condition, 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 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.

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 condition, 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

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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 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.

The Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, 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 unpermitted disclosures of PHI. A final rule was submitted by the Secretary in 2010, but later withdrawn. The final rule was issued on January 17, 2013.

Failure to comply with either HIPAA or HITECH 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.

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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 condition, 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.

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. Significant disruptions to our infrastructure or any of our facilities due to failure of technology or some other catastrophic event could adversely impact our business.

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 condition, 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.

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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 $268.2 million of goodwill and $121.9 million of recorded intangible assets on our consolidated balance sheet as of December 31, 2012. 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.

The risk of transitioning information technology services being provided by the Corporation s current vendor to another effectively.

Historically, we have obtained substantially all of our information services from Kindred pursuant to an IT services agreement. During the year ended December 31, 2012 we began to transition our IT technology services to another vendor. This transition will continue into 2013. If the transition is not successful, 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 condition, 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 condition, results of operations and liquidity.

Our revenues and volume trends may be adversely affected by certain factors relevant to the markets in which we have pharmacies, including weather conditions and other natural disasters.

Our revenues and volume trends will be predicated on many factors, including physicians pharmaceutical decisions on patients, payer programs, seasonal and severe weather conditions including the effects of extreme low temperatures, hurricanes and tornadoes, earthquakes, current local economic and demographic changes. Any

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of these factors could have a material adverse effect on our revenues and volume trends, and many of these factors will not be within the control of our management. These factors may also have an effect on our customers and their ability to continue to operate. For further discussion, see Note 9.

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 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.

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;

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

general economic and industry conditions.

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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.

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, 2012, we had outstanding debt of $315.5 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 $315.5 million in indebtedness outstanding as of December 31, 2012 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 condition.

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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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 in various locations throughout the United States. The Corporation s corporate headquarters are located in Louisville, Kentucky. In addition to the pharmacies listed below, the Corporation also has five facilities throughout the nation with several overhead and administrative functions. As of December 31, 2012, all facilities were leased. We consider all of these facilities to be suitable, adequate, and are utilized at full capacity.

The following table presents certain information with respect to operating leases of our pharmacies identified by the Corporation as properties as of December 31, 2012:

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	4	28,971	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	82,500
Hawaii	5	15,506	North Carolina	4	26,950
Idaho	1	4,031	Ohio	2	26,125
Illinois	1	15,495	Oklahoma	1	6,048
Indiana	1	20,386	Pennsylvania	7	53,508
Iowa	1	6,250	Rhode Island	1	9,415
Kansas	1	9,977	South Carolina	1	15,550
Kentucky	2	43,500	South Dakota	2	12,050
Louisiana	1	4,914	Tennessee	5	47,837
Maine	1	10,200	Texas	14	102,514
Maryland	1	10,744	Utah	2	15,002
Massachusetts	1	53,111	Virginia	2	15,807
Michigan	2	13,720	Washington	2	14,792
Minnesota	1	13,871	West Virginia	1	1,419
			Wisconsin	1	11,068

Item 3. Legal Proceedings

The Corporation is responding to investigations by the U.S. Attorneys 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 investigations. If the government brings claims and the Corporation is not successful in defending them, it could result in material fines and recoupment of government claims which could result in a material adverse effect to our consolidated financial condition, results of operations, or liquidity.

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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 condition, 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.

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 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
Fiscal 2012			
First Quarter	$ 15.54	$ 12.00	$ 12.43
Second Quarter	$ 12.90	$ 9.03	$ 10.92
Third Quarter	$ 13.40	$ 9.82	$ 12.66
Fourth Quarter	$ 14.74	$ 12.22	$ 14.24

Stockholders

As of January 31, 2013, we had approximately 2,860 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.

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 reserved for substitute equity awards. 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 share awards, restricted stock units and performance share

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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, 2012:

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted-average exercise price of outstanding options, warrants 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	3,557,620(1)	$ 15.14(2)	3,015,100(3)

(1) Includes the following:

2,424,285 shares of common stock to be issued upon exercise of outstanding stock options granted under the Omnibus Plan;

460,745 shares of common stock to be issued upon vesting of performance share units under the Omnibus Plan;

7,831 shares of common stock to be issued upon vesting of restricted stock awards under the Omnibus Plan; and

664,759 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 1,133,335 shares of common stock potentially to be issued under restricted stock awards, performance share units and restricted stock units.

(3) The 3,015,100 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 2,331,162.

See Note 10 to the Consolidated Financial Statements included in this Report for information regarding the material features of the Omnibus Plan.

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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 December 31, 2007 to December 31, 2012. This graph assumes an investment in the Corporation s common stock and the indices of $100 on December 31, 2007 and that all dividends were reinvested:

	PharMerica Corporation	S&P 500	S&P Healthcare
December 31, 2007	$ 100.00	$ 100.00	$ 100.00
March 31, 2008	119.38	90.08	88.06
June 30, 2008	162.75	87.17	86.53
September 30, 2008	162.03	79.43	86.53
December 31, 2008	112.90	61.51	75.52
March 31, 2009	119.88	54.34	69.09
June 30, 2009	141.43	62.61	74.80
September 30, 2009	133.79	71.99	81.46
December 31, 2009	114.41	75.94	88.41
March 31, 2010	131.27	79.64	90.96
June 30, 2010	105.62	70.19	79.78
September 30, 2010	68.66	77.72	86.34
December 31, 2010	82.49	85.65	89.04
March 31, 2011	82.42	90.29	93.48
June 30, 2011	91.93	89.94	100.30
September 30, 2011	102.81	77.05	89.76
December 31, 2011	109.37	85.65	98.10
March 31, 2012	89.55	95.92	106.36
June 30, 2012	78.67	92.77	107.58
September 30, 2012	91.21	98.11	113.57
December 31, 2012	102.59	97.13	113.00

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Recent Sales of Unregistered Securities

None.

Purchases of Equity Securities by the Issuer and Affiliated Purchasers

On August 24, 2010, the Corporation announced a stock repurchase program where the Corporation is authorized to repurchase up to $25.0 million of the Corporation s common stock, of which $10.5 million was used to purchase the Corporation s common stock. On July 2, 2012, the Board of Directors authorized an increase to the existing stock repurchase program that will allow the Corporation to again purchase back up to a maximum of $25.0 million of the Corporation s common stock. The stock repurchase program does not have an expiration date and may be limited, terminated or extended at any time without prior notice. The Corporation did not repurchase shares under this program for the three months ended December 31, 2012.

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 946 shares of certain vested awards for an aggregate price of less than $0.1 million during the three months ended December 31, 2012.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2012:

Period	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as Part of a Publicly Announced Plans or Program (2)	Approximate Dollar Value of Shares that may yet be Purchased under the Plans or Programs (in millions)
October 1, 2012 October 31, 2012	57(1)	$ 12.40		$ 24.0
November 1, 2012 November 30, 2012				24.0
December 1, 2012 December 31, 2012	889(1)	14.07		24.0

(1) The Corporation repurchased 946 shares of common stock in connection with the vesting of certain stock awards to cover minimum statutory withholding taxes.
(2) The Corporation did not repurchase shares under the stock repurchase program for the three months ended December 31, 2012.

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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,				
	2008	2009	2010	2011	2012
Statement of operations data:					
Revenues	$ 1,947.3	$ 1,841.2	$ 1,847.3	$ 2,081.1	$ 1,832.6
Cost of goods sold	1,658.9	1,563.3	1,604.8	1,786.2	1,532.4
Gross profit	288.4	277.9	242.5	294.9	300.2
Selling, general and administrative	217.9	193.2	182.8	216.5	214.7
Amortization expense	6.5	9.0	9.3	11.0	12.3
Impairment of intangible assets	14.8			5.1	
Merger, acquisition, integration costs and other	26.7	5.2	14.6	15.3	19.9
Hurricane Sandy disaster costs					4.5
Operating income (1)	$ 22.5	$ 70.5	$ 35.8	$ 47.0	$ 48.8
Net income	$ 5.0	$ 42.2	$ 19.2	$ 23.4	$ 22.9
Earnings per common share: (2)					
Basic	$ 0.17	$ 1.39	$ 0.64	$ 0.80	$ 0.78
Diluted	$ 0.17	$ 1.39	$ 0.64	$ 0.79	$ 0.77
Adjusted earnings per diluted common share (3)	$ 1.00	$ 1.30	$ 0.93	$ 1.20	$ 1.27
Shares used in computing earnings per common share:					
Basic	30.1	30.3	30.0	29.3	29.5
Diluted	30.2	30.4	30.1	29.5	29.9
Balance sheet data:					
Cash and cash equivalents	$ 41.3	$ 51.2	$ 10.8	$ 17.4	$ 12.3
Working capital (4)	$ 272.3	$ 312.8	$ 280.9	$ 348.4	$ 323.3
Goodwill (4)	$ 113.7	$ 140.1	$ 179.4	$ 214.9	$ 268.2
Intangible assets, net	$ 73.4	$ 90.8	$ 102.2	$ 100.2	$ 121.9
Total assets (4)	$ 679.2	$ 724.3	$ 759.7	$ 834.0	$ 885.7
Long-term debt, including current portion	$ 240.0	$ 240.0	$ 245.6	$ 300.0	$ 315.5
Total stockholder s equity	$ 319.8	$ 370.9	$ 384.4	$ 413.8	$ 442.6
Supplemental information:					
Adjusted EBITDA (3)	$ 92.5	$ 102.7	$ 78.5	$ 98.5	$ 104.1
Adjusted EBITDA Margin (3)	4.8%	5.6%	4.2%	4.7%	5.7%
Adjusted EBITDA per prescription dispensed (3)	$ 2.29	$ 2.63	$ 2.08	$ 2.36	$ 2.65
Net cash provided by operating activities	$ 65.7	$ 85.0	$ 98.2	$ 26.8	$ 85.7
Net cash used by investing activities	$ (47.4)	$ (76.1)	$ (133.2)	$ (64.0)	$ (105.3)
Net cash (used in) provided by financing activities	$ (9.0)	$ 1.0	$ (5.4)	$ 43.8	$ 14.5
Statistical information (in whole numbers except where indicated)					
Institutional Pharmacy					
Financial Data:					
Prescriptions dispensed (in thousands)	40,319	39,037	37,826	41,677	39,212
Revenue per prescription dispensed	$ 46.85	$ 45.72	$ 47.31	$ 48.43	$ 44.99
Gross profit per prescription dispensed	$ 6.88	$ 6.90	$ 6.21	$ 6.89	$ 7.44
Institutional pharmacy gross margin	14.7%	15.1%	13.1%	14.2%	16.5%
Generic drug dispensing rate (5)	70.7%	74.6%	76.5%	79.6%	83.3%
Customer licensed beds under contract:					
Beginning of period	336,759	320,862	313,364	361,154	337,213
Additions	21,398	35,921	95,949	30,460	21,198
Losses	(37,295)	(43,419)	(48,159)	(54,401)	(51,403)

End of period	320,862	313,364	361,154	337,213	307,008
Hospital management contracts serviced	84	86	90	91	89

(1) Includes depreciation expense of $22.0 million, $18.0 million, $18.8 million, $20.1 million and $18.6 million for the years ended December 31, 2008, 2009, 2010, 2011 and 2012, respectively.
(2) The Corporation has never declared a cash dividend. Earnings per share in whole dollars and cents.
(3) 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 to Adjusted EBITDA and Margin.
(4) As adjusted, see Note 2 Acquisitions in the Consolidated Financial Statements.
(5) Single source generic drugs, previously classified as brand drugs, are now being classified as generics for purposes of the generic dispensing rate calculation in all periods.

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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 are reconciliations of Adjusted EBITDA to the Corporation s net income and net operating cash flows for the periods presented.

The Corporation calculates and uses adjusted diluted earnings per share, which is exclusive of the impact of merger, acquisition, integration costs and other charges, Hurricane Sandy disaster costs, impairment of intangible assets, and tax accounting matters as an indicator of its core operating results. The measurement is used in concert with net income and diluted earnings per 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 diluted earnings per share, which is exclusive of the impact of merger, acquisition, integration costs and other charges, Hurricane Sandy disaster costs, impairment of intangible assets, 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 diluted earnings per share as measured under GAAP. The impact of merger, acquisition, integration costs and other charges, Hurricane Sandy disaster costs, impairment of intangible assets, and tax accounting matters excluded from the diluted earnings per share are significant components of the accompanying consolidated income statements and must be considered in performing a comprehensive assessment of overall financial performance. The following is a reconciliation of adjusted diluted earnings per share to the Corporation s GAAP earnings per diluted common share for the periods presented.

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Reconciliation of Net Income to Adjusted EBITDA

	Years Ended December 31,				
	2008	2009	2010	2011	2012
Net income	$ 5.0	$ 42.2	$ 19.2	$ 23.4	$ 22.9
Add:					
Interest expense, net	14.2	9.4	3.6	8.8	10.0
Merger, acquisition, integration costs and other charges	26.7	5.2	14.6	15.3	19.9
Hurricane Sandy disaster costs					4.5
Provision for income taxes	3.3	18.9	13.0	14.8	15.9
Impairment of intangible assets	14.8			5.1	
Depreciation and amortization expense	28.5	27.0	28.1	31.1	30.9
Adjusted EBITDA	$ 92.5	$ 102.7	$ 78.5	$ 98.5	$ 104.1
Adjusted EBITDA Margin	4.8%	5.6%	4.2%	4.7%	5.7%

Reconciliation of Adjusted EBITDA to Net Operating Cash Flows

	Years Ended December 31,				
	2008	2009	2010	2011	2012
Adjusted EBITDA	$ 92.5	$ 102.7	$ 78.5	$ 98.5	$ 104.1
Interest expense, net	(14.2)	(9.4)	(3.6)	(8.8)	(10.0)
Provision benefit for income taxes	(3.3)	(18.9)	(13.0)	(14.8)	(15.9)
Merger, acquisition, integration costs and other charges	(22.2)	(4.8)	(14.0)	(13.8)	(18.6)
Hurricane Sandy disaster costs					(3.0)
Provision for bad debt	24.7	16.6	18.5	24.8	25.2
Stock-based compensation and deferred compensation	5.3	5.0	5.2	6.0	7.1
Amortization of deferred financing fees	0.4	0.4	0.6	0.8	1.0
Loss on disposition of equipment	0.2	0.3	0.3	0.1	0.1
Deferred income taxes	2.8	19.7	12.3	13.9	2.8
Other	(0.5)	(0.3)		0.2	0.2
Changes in assets and liabilities	(20.0)	(26.3)	13.4	(80.1)	(7.3)
Net Cash Flows from Operating Activities	$ 65.7	$ 85.0	$ 98.2	$ 26.8	$ 85.7

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

	Years Ended December 31,				
	2008	2009	2010	2011	2012
Diluted earnings per share	$ 0.17	$ 1.39	$ 0.64	$ 0.79	$ 0.77
Add:					
Diluted earnings per share impact of:					
Impairment of intangible assets	0.30			0.11	
Merger, acquisition, integration costs and other charges	0.53	0.10	0.29	0.32	0.40
Hurricane Sandy disaster costs					0.09
Tax accounting matters		(0.19)		(0.02)	0.01
Adjusted diluted earnings per share after impact of above items	$ 1.00	$ 1.30	$ 0.93	$ 1.20	$ 1.27

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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 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;

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

the Corporation s risk of loss of revenues due to a customer or owner of skilled nursing facility entering the institutional pharmacy business;

the demand for the Corporation s products and services;

the risk 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 Corporation s ability to successfully transition information technology services being provided by its current vendor to another vendor effectively;

the impacts of cyber security risks and/or incidents;

the effects of a failure in the security or stability of our technology infrastructure, or the infrastructure of one or more of our key vendors, or a significant failure or disruption in service;

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, including, the dispensing of antipsychotic prescriptions;

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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;

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;

the uncertainty as to the long-term value of the Corporation s common stock;

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;

the effect on prescription volumes and the Corporation s net revenues and profitability 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;

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, 2012.

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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 that services healthcare facilities, provides pharmacy management services to hospitals and also provides specialty infusion services to patients outside a hospital setting. The Corporation is the second largest institutional pharmacy services company in the United States based on revenues and customer licensed beds under contract, operating 91 institutional pharmacies and 12 specialty infusion pharmacies in 45 states. The Corporation s customers are typically institutional healthcare providers, such as skilled nursing facilities, nursing centers, assisted living facilities, hospitals, individuals receiving in-home care 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 89 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. 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.

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.

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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.

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, 2012, 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 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, 2011 and 2012, were $48.6 million and $56.4 million, respectively.

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

	Amount	% of Revenues
2010		
First Quarter	$ 3.8	0.8%
Second Quarter	4.6	1.0
Third Quarter	4.5	1.0
Fourth Quarter	5.6	1.1
2011		
First Quarter	$ 5.4	1.0%
Second Quarter	5.8	1.1
Third Quarter	6.4	1.2
Fourth Quarter	7.2	1.5
2012		
First Quarter	$ 6.2	1.2%
Second Quarter	6.2	1.4
Third Quarter	7.3	1.7
Fourth Quarter*	5.5	1.3

* Excludes a $0.7 million expense related to Hurricane Sandy. See further discussion in Note 9.

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. 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 payers. 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 payers, 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:

	2010	2011	2012
First Quarter	40.5	39.0	42.8
Second Quarter	40.4	41.6	45.4
Third Quarter	40.3	42.5	44.1
Fourth Quarter	39.7	42.8	44.1

Sensitivity Analysis

If our provision as a percent of institutional revenue increases 0.10%, our after tax income would decrease by approximately $1.1 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
2010			
First Quarter	$ 37.6	$ 241.8	15.6%
Second Quarter	37.1	237.6	15.6
Third Quarter	38.1	231.9	16.4
Fourth Quarter	36.8	263.3	14.0
2011			
First Quarter	$ 38.1	$ 273.9	13.9%
Second Quarter	39.6	282.4	14.0
Third Quarter	42.9	282.8	15.2
Fourth Quarter	48.6	280.8	17.3
2012			
First Quarter	$ 52.1	$ 296.4	17.6%
Second Quarter	52.8	272.1	19.4
Third Quarter	56.1	266.0	21.1
Fourth Quarter	56.4	262.9	21.5

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

Assumptions/Approach Used

The following table shows our summarized aging categories by quarter:

	0 to 60 days	61 to 120 days	Over 120 Days
2010			
First Quarter	66.2%	17.8%	16.0%
Second Quarter	65.7%	18.0%	16.3%
Third Quarter	62.9%	19.2%	17.9%
Fourth Quarter	61.8%	22.0%	16.2%
2011			
First Quarter	63.4%	19.3%	17.3%
Second Quarter	63.9%	18.0%	18.1%

Third Quarter	63.1%	18.9%	18.0%
Fourth Quarter	61.2%	19.5%	19.3%
2012			
First Quarter	61.5%	17.3%	21.2%
Second Quarter	58.0%	17.7%	24.3%
Third Quarter	58.6%	15.7%	25.7%
Fourth Quarter	58.8%	17.1%	24.1%

Sensitivity Analysis

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Revenue recognition/Allowance for contractual discounts

We recognize revenues at the time services are provided or products are delivered.

Our sources of revenues for the years ended December 31, 2010, 2011, and 2012 are as follows:

	2010 % of Revenues	2011 % of Revenues	2012 % of Revenues
Medicare Part D	46.5%	48.0%	47.6%
Institutional healthcare providers	30.1	29.6	30.6
Medicaid	9.2	10.4	9.1
Private and other	5.8	4.5	4.6
Insured	4.9	4.3	4.3
Medicare	0.4	0.2	0.3
Hospital management fees	3.1	3.0	3.5
Total	100.0%	100.0%	100.0%

Our sources of revenues for the quarters ended March 31, June 30, September 30, and December 31, 2010, 2011, and 2012 are as follows:

	Three Months Ended March 31,			Three Months Ended June 30,		
	2010	2011	2012	2010	2011	2012
Medicare Part D	46.8%	47.7%	48.2%	45.8%	47.5%	48.1%
Institutional healthcare providers	30.4	30.7	30.0	30.5	29.8	30.2
Medicaid	8.7	10.4	9.6	8.9	10.7	9.2
Private and other	5.7	4.0	4.7	6.1	4.6	4.7
Insured	4.9	4.1	4.1	5.1	4.2	4.1
Medicare	0.5	0.2	0.2	0.4	0.2	0.2
Hospital management fees	3.0	2.9	3.2	3.2	3.0	3.5
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended September 30,			Three Months Ended December 31,		
	2010	2011	2012	2010	2011	2012
Medicare Part D	46.2%	48.3%	47.4%	47.2%	48.3%	46.8%
Institutional healthcare providers	30.0	29.7	31.3	29.5	28.5	31.1
Medicaid	8.9	10.4	8.7	10.2	10.2	8.7
Private and other	6.0	4.6	4.4	5.5	4.6	4.6
Insured	5.0	3.8	4.4	4.5	5.1	4.9
Medicare	0.4	0.2	0.2	0.3	0.2	0.3

Hospital management fees	3.5	3.0	3.6	2.8	3.1	3.6
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Please refer to Note 7 to our consolidated financial statements included elsewhere in this report for a detailed discussion of our revenue recognition policies.

Assumptions/Approach Used

We recognize revenues at the time services are provided or products are delivered. A significant portion of our revenues are billed to PDPs under Medicare Part D, the state Medicaid programs, long-term care institutions, third party insurance companies, and private payers. Some claims are electronically adjudicated through online processing at the point the prescription is dispensed such that our operating system is automatically updated with the actual amount to be reimbursed. As a result, our revenues and the associated receivables are based upon the actual reimbursement to be received. For claims that are adjudicated on-line and are rejected or otherwise denied upon submission, the Corporation provides contractual allowances based upon historical trends, contractual reimbursement terms and other factors which may impact ultimate reimbursement. Amounts are adjusted to actual reimbursed amounts based upon cash receipts.

Co-payments for our services can be applicable under Medicare Part D, the state Medicaid programs, and certain third party payers and are typically not collected at the time products are delivered or services are provided. Co-payments under the Medicaid programs and third party plans are generally billed to the responsible party as part of our normal billing procedures which are subject to normal collection procedures.

Under Medicare Part D, institutional residents who are dual eligible have co-payments due for up to the first thirty days of a beneficiary s stay in a skilled nursing facility subsequent to which the PDP s are responsible for reimbursement.

Under certain circumstances, including state-mandated return policies under various Medicaid programs, we accept returns of medications and issue credit memorandums to the applicable payer. Product returns are generally processed in the period returned. We estimate an amount for expected returns based on historical trends.

Our hospital pharmacy management revenues represent contractually defined management fees and the reimbursement of costs associated with the direct operations of hospital pharmacies, which are primarily comprised of personnel costs.

Sensitivity Analysis

If our reimbursement declined or was negatively impacted 0.25% of revenues, the negative impact on net income would be $2.7 million or $0.09 per diluted common share.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Inventory and cost of drugs dispensed

We have inventory located at each of our institutional pharmacy and specialty infusion locations. Our inventory is valued at the lower of first-in, first-out cost or market basis. The inventory consists of prescription drugs, over the counter products and intravenous solutions. Our inventory relating to controlled substances is maintained on a manually prepared perpetual system to the extent required by the Drug Enforcement Agency and state board of pharmacies. All other inventory is maintained on a periodic system, through the performance of quarterly physical inventories at the end of each quarter. All inventory counts are reconciled to the balance sheet account and differences are adjusted through cost of goods sold. In addition, we record an amount of potential returns of prescription drugs based on historical rates of returns.

At December 31, 2011 and 2012, our inventory on our consolidated balance sheets was as follows (dollars in millions):

2011 $130.6

2012 $135.7

Our annualized inventory turns were as follows:

	2010	2011	2012
First Quarter	15.7	15.0	11.0
Second Quarter	15.5	12.0	10.6
Third Quarter	15.3	11.0	10.3
Fourth Quarter	15.6	10.3	8.9

We receive rebates on purchases from various vendors and suppliers.

Please refer to Note 1 to our consolidated financial statements included elsewhere in this report for a detailed discussion of our inventory.

Assumptions/Approach Used

Our inventory is valued at the lower of first-in, first-out cost or market basis. Our controlled prescription drugs are maintained on a perpetual inventory basis to the extent required by the DEA. All other inventory is maintained on a periodic basis. We perform quarterly inventory counts at all locations with the use of our personnel and the use of third party inventory count teams under our supervision. We perform quarterly inventory counts in the third month of each quarter.

All inventory counts are reconciled to the balance sheet account and differences are adjusted through cost of goods sold. In addition, we record an amount of potential returns of prescription drugs based on historical rates of returns.

We account for rebates and other incentives received from vendors and suppliers, relating to the purchase or distribution of inventory, as a reduction to cost of goods sold and inventory. We consider these rebates to represent product discounts, and as a result, the rebates are allocated as a reduction of product cost and relieved through cost of goods sold upon the sale of the related inventory.

Sensitivity Analysis

Actual inventory counts may include estimates based on amounts that may be dispensed from an open container. In addition, items are reviewed for potential obsolescence.

A 1.0% error rate in the count of prescription drugs in inventory would impact net income $0.8 million, or $0.03 per diluted common share.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Goodwill, other intangible assets and accounting for business combinations

Goodwill represents the excess of the purchase price over the fair value of the net assets of acquired companies. Our intangible assets are comprised primarily of trade names, customer relationship assets, and non-compete agreements.

Our goodwill included in our consolidated balance sheet as of December 31, 2011 and 2012 was as follows (dollars in millions):

2011 $214.9

2012 $268.2

Our net intangible assets, included in our consolidated balance sheets as of December 31, 2011 and 2012 were as follows (dollars in millions):

	2011	2012
Customer relationships	$ 96.0	$ 98.8
Trade name	30.0	57.0
Non-competition agreements	8.4	12.6
	134.4	168.4
Accumulated Amortization	(34.2)	(46.5)
	$ 100.2	$ 121.9

Please refer to Note 4 to our consolidated financial statements included elsewhere in this report for a detailed roll forward of our goodwill and intangible assets.

Assumptions/Approach Used

The Corporation performs an annual, and more frequent if necessary, qualitative assessment of its Institutional Pharmacy reporting unit to determine if it is necessary to proceed to the first step of the two-step goodwill impairment test. The Corporation is not required to do so unless, based on the qualitative assessment, it is determined that it is more likely than not that the fair value of the reporting unit is less than its carrying amount. The qualitative analysis requires the Corporation to examine a wide range of factors, including macro economic factors, industry and market considerations, overall financial performance of the Corporation, and other relevant entity specific factors affecting a reporting unit such as a change in the composition or carrying amount of its net assets, and changes in share price. If the Corporation must continue to step one, then we determine fair value using widely accepted valuation techniques, including discounted cash flow and market multiple analyses. These types of analyses require us to make assumptions and estimates regarding future cash flows, industry economic factors and the profitability of future business strategies.

The purchase price of acquisitions are allocated to the assets acquired and liabilities assumed based upon their respective fair values. Such valuations require us to make significant estimates and assumptions, including projections of future events and operating performance.

Fair value estimates are determined by management based upon established market values of comparable assets, or internal calculations of estimated future net cash flows. Our estimate of future cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. The ultimate decision of allocations are that of management.

We assess for the potential impairment of intangible assets and finite lived assets recorded on the Corporation s balance sheet whenever events or changes in circumstances indicate that their carrying amount may not be recoverable.

During the third quarter of 2011, the Corporation recorded a pre-tax impairment charge of $5.1 million related to finite-lived customer relationships. The impairment was incurred as the result of non-renewal of certain customer contracts. The impairment was related to intangible assets acquired in an acquisition during the year ended December 31, 2005. These asset groups were assessed for recoverability and management determined the finite-lived customer relationship assets to be impaired. No other assets within the asset groups were deemed impaired. Using a discounted cash flow analysis, the Corporation determined that the pre-tax impairment charge of $5.1 million was required to write the carrying value down to fair value, resulting in a decrease per diluted common share impact of $0.11. The Corporation recognized the impairment as a permanent write-down of the cost basis and accumulated amortization of the affected assets. No such impairment changes were taken for the years ended December 31, 2010 or December 31, 2012.

Sensitivity Analysis

We performed our annual testing for goodwill impairment as of December 31, 2011 and 2012 and determined that no goodwill impairment existed. If actual future results are not consistent with our assumptions and estimates, we may be required to record goodwill impairment charges in the future. Our estimate of fair value of acquired assets and assumed liabilities are based upon assumptions believed to be reasonable based upon current facts and circumstances.

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Balance Sheet or Income Statement Caption/ Nature of Critical Estimate Item	

Accounting for income taxes

The provision for income taxes is based upon the Corporation s annual income or loss for each respective accounting period. The Corporation recognizes an asset or liability for the deferred tax consequences of temporary differences between the tax basis of assets and liabilities and their reported amounts in the consolidated financial statements. Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in the accompanying consolidated income statements. The Corporation also recognizes as deferred tax assets the future tax benefits from net operating and capital loss carryforwards.

We assess the likelihood that deferred tax assets will be realized from future taxable income. A valuation allowance is provided for deferred tax assets if it is more-likely-than-not that some portion or all of the net deferred tax assets will not be realized. Our deferred tax asset balances in our consolidated balance sheets as of December 31, 2011 and 2012 were as follows (dollars in millions), including the impact of valuation allowances:

2011 $ 37.1

2012 $ 25.6

At December 31, 2012 the Corporation also had a deferred tax liability of $11.1 million.

Our valuation allowances for deferred tax assets in our consolidated balance sheets as of December 31, 2011 and 2012 were as follows (dollars in millions):

2011 $ 1.0

2012 $ 1.0

Significant judgment is required in determining and assessing the impact of uncertain tax positions. For an identified uncertain tax position to qualify for benefit recognition, the position must have at least a more-likely-than-not chance of being sustained on its technical merits if challenged by relevant taxing authorities and taken by management to the court of last resort. If an uncertain position does not meet this recognition threshold based on our analysis of applicable tax law, we establish a liability for the realized, but unrecognized tax benefit. As of December 31, 2012, the Corporation has no liability recorded for unrecognized tax benefits for U.S. federal and state tax jurisdictions. The Corporation records accrued interest and penalties associated with uncertain tax positions as income tax expense in the consolidated income statements. We recognize the benefit for an uncertain tax position we have taken upon any one of the following conditions: 1) the recognition threshold is met due to changes in facts, circumstances and information available at the reporting date; 2) the tax position is effectively settled through examination, negotiation or litigation; or 3) the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired.

Please refer to Note 11 to our consolidated financial statements included elsewhere in this report for a detailed discussion of our accounting for income taxes.

Assumptions/Approach Used

The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in step one of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.

Tax benefits from uncertain tax positions are recognized in the Corporation s consolidated financial statements if it is more-likely-than-not that the position is sustainable based on the technical merits of the position. In evaluating whether the position has met this recognition threshold, the Corporation assumes that the appropriate taxing authority has full knowledge of all relevant information. The amount of benefit recognized in the Corporation s consolidated financial statements for a tax position meeting the recognition threshold is determined by a measurement of the largest amount of benefit that is more than 50 percent likely to be realized upon ultimate settlement.

Subsequent recognition, derecognition and measurement of uncertain tax positions is based on management s best judgment given the facts, circumstances, and information available at the reporting date.

With respect to net deferred tax assets, the Corporation considers all available positive and negative evidence to determine whether a valuation allowance is needed. This includes an analysis of net operating loss carryforwards available under law, anticipated future income or loss, as well as tax planning strategies. If the cumulative weight of evidence suggests that it is more-likely-than-not that all or some portion of the net deferred tax assets will not be realized, a full or partial valuation allowance will be recognized based upon the qualitative and quantitative evidence examined.

Sensitivity Analysis

Our deferred tax assets exceeded our deferred tax liabilities by $25.6 million as of December 31, 2012, including the impact of valuation allowances. Historically, we have produced taxable income and we expect to generate taxable income in future years. Therefore, we believe that the likelihood of our not realizing the tax benefit of our deferred tax assets is remote.

While we have generated taxable income in recent years and expect to continue to do so in the future, we have deferred tax assets in select states, including tax loss carryforwards that we expect to expire before we are able to fully use them to offset taxable income. We have recorded a valuation allowance against these deferred tax assets. If our conclusion about our ability to realize these deferred tax assets is incorrect, then our deferred tax assets would be understated or overstated at December 31, 2012.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments we would incur additional tax payments for 2011 and 2012 plus the applicable penalties and interest.

The federal statute of limitations remains open for tax years 2009 through 2011. The Corporation s consolidated U.S. income tax returns for 2010 and 2011 are currently under examination by the IRS.

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Key Financial Statement Components

Consolidated Income Statements

Our revenues are comprised primarily of product and infusion service revenues and are derived from the sale of prescription drugs through our pharmacies. The majority of our product and service revenues are derived on a fee-for-service basis. Our revenues are recorded net of certain discounts and estimates for returns. Hospital pharmacy revenues represent management fees and pass through costs associated with managing the clients hospital pharmacy.

Cost of goods sold is comprised primarily of the cost of product and is principally attributable to the dispensing of prescription drugs. Our cost of product relating to drugs dispensed by our pharmacies consists primarily of the cost of inventory dispensed and our costs incurred to process and dispense the prescriptions. Cost of goods also includes direct labor, delivery costs, rent, utilities, depreciation, travel costs, professional fees and other costs attributable to the dispensing of medications. In addition, cost of product includes a credit for rebates earned directly or indirectly from pharmaceutical manufacturers whose drugs are included in our formularies. These rebates generally take the form of formulary rebates, which are earned based on the volume of a specific drug dispensed, or market share rebates, which are earned based on the achievement of contractually specified market share levels. The Corporation receives rebates on brand and generic drugs dispensed and other administrative rebates.

Selling, general and administrative expenses reflect the costs of operations dedicated to executive management, the generation of new sales, maintenance of existing client relationships, management of clinical programs, enhancement of technology capabilities, direction of pharmacy operations, human resources and performance of reimbursement and collection activities, in addition to finance, legal and other staff activities.

Merger, acquisition, integration costs, and other charges represent the costs associated with integrating our operations, as well as costs related to acquisitions. Also included in this category are costs related to the unsolicited tender offer by Omnicare and costs related to the transition of the information technology services being provided by the Corporation s current vendor to another vendor (IT Transition).

Hurricane Sandy disaster costs reflect costs associated with damages caused by Hurricane Sandy in October 2012 and the related recovery from the effects of the storm to the Corporation s operations.

Interest expense, net, primarily includes interest expense relating to our senior secured credit facility, partially offset by interest income generated by cash and cash equivalents.

Consolidated Balance Sheets

Our assets include cash and cash equivalent investments, accounts receivable, inventory, fixed assets, deferred tax assets, goodwill and intangibles.

Cash reflects the accumulation of positive cash flows from our operations and financing activities, and primarily includes deposits with banks or other financial institutions. Our cash balances are at the highest on Thursday nights and at the lowest on Friday nights. Friday is usually our largest cash disbursement day as a result of payments for our drug costs and our payrolls.

Accounts receivable primarily consist of amounts due from PDPs under Medicare Part D, the respective state Medicaid programs, long-term care institutions, third party insurance companies, and private payers, net of allowances for doubtful accounts, as well as contractual allowances.

Inventory reflects the cost of prescription products held for dispensing by our pharmacies, net of allocated rebates, and is recorded on a first-in, first-out basis. We perform quarterly inventory counts and record our inventory and cost of goods sold based on such quarterly inventories. We also include an estimate for returns on inventory.

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Deferred tax assets primarily represent temporary differences between the financial statement basis and the tax basis of certain accrued expenses, goodwill, accounts receivable allowance, net operating loss carryforwards, and stock-based compensation.

Fixed assets include investments in our pharmacies and information technology, including capitalized software development. Goodwill and intangible assets are comprised primarily of goodwill and intangibles related to our previous acquisitions.

Our primary liabilities include accounts payable, accrued salaries and wages, other current liabilities, debt, and deferred tax liabilities. Accounts payable primarily consist of amounts payable for prescription inventory purchases under our Amended Prime Vendor Agreement and other purchases made in the normal course of business. The balances in accounts payable and accrued salaries and wages are at the highest on Thursday nights and at the lowest on Friday nights, as a result of payments for drug costs and payroll being funded on Friday. Accrued expenses and other current liabilities primarily consist of employee and facility-related cost accruals incurred in the normal course of business, as well as income taxes payable.

Our debt is primarily comprised of loans under our senior secured credit facility as well as our revolver. Deferred tax liabilities primarily represent temporary differences between the financial statement basis and tax basis of fixed assets and tax deductible goodwill. We do not have any off-balance sheet arrangements, other than purchase commitments and lease obligations.

Consolidated Statements of Cash Flows

An important element of our operating cash flows is the timing of billing cycles, subsequent cash collections and payments for drug costs and labor. Due to the nature of the Corporation s cash cycle, cash flows from operations can fluctuate significantly depending on the day of the week of the respective close process. We pay for our prescription drug inventory in accordance with payment terms offered under our Amended Prime Vendor Agreement. The Corporation receives rebates from its prime vendor and suppliers each period. Rebates are allocated as reduction in inventory and also recorded as a reduction to cost of goods sold in the period earned. Outgoing cash flows include inventory purchases, employee payroll and benefits, facility operating expenses, capital expenditures including technology investments, interest and principal payments on our outstanding debt, and income taxes. The cost of acquisitions will also result in cash outflows.

Definitions

Listed below are definitions of terms used by the Corporation in managing the business. The definitions are necessary to the understanding of the Management s Discussion and Analysis section of this document.

Bps: Represents basis points. Basis points are based on percentages. For example, 100 bps represents a change of 1.0%.

Gross profit per prescription dispensed: Represents the gross profit from the institutional pharmacy segment divided by the total prescriptions dispensed.

Institutional pharmacy gross margin: Represents the gross profit per prescription dispensed divided by the revenue per prescription dispensed.

NM: Represents not meaningful.

Prescriptions dispensed: Represents a prescription filled for an individual patient. A prescription will usually be for a 15 or 30 day period and will include only one drug type.

Revenues per prescription dispensed: Represents the revenues from the institutional pharmacy segment divided by the total prescriptions dispensed.

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Results of Operations

The following table presents selected consolidated comparative results of operations and statistical information for the periods presented (dollars in millions, except per prescription and per patient amounts, and prescriptions in thousands):

	Years Ended December 31,									
	2010		Increase (Decrease)		2011		Increase (Decrease)		2012	
	Amount	% of Revenues			Amount	% of Revenues			Amount	% of Revenues
Net revenues:										
Institutional Pharmacy	$ 1,789.4	96.9%	$ 229.2	12.8%	$ 2,018.6	97.0%	$ (254.3)	(12.6)%	$ 1,764.3	96.3%
Hospital Management and other	57.9	3.1	4.6	7.9	62.5	3.0	5.8	9.3	68.3	3.7
Total net revenues	1,847.3	100.0	233.8	12.7	2,081.1	100.0	(248.5)	(11.9)	1,832.6	100.0
Cost of goods sold:										
Institutional Pharmacy	1,554.4	84.2	177.0	11.4	1,731.4	83.2	(258.9)	(15.0)	1,472.5	80.4
Hospital Management and other	50.4	2.7	4.4	8.7	54.8	2.6	5.1	9.3	59.9	3.2
Total cost of goods sold	1,604.8	86.9	181.4	11.3	1,786.2	85.8	(253.8)	(14.2)	1,532.4	83.6
Gross profit:										
Institutional Pharmacy	235.0	12.7	52.2	22.2	287.2	13.8	4.6	1.6	291.8	15.9
Hospital Management and other	7.5	0.4	0.2	2.7	7.7	0.4	0.7	9.1	8.4	0.5
Total gross profit	$ 242.5	13.1%	$ 52.4	21.6%	$ 294.9	14.2%	$ 5.3	1.8%	$ 300.2	16.4%
Institutional Pharmacy (in whole numbers except where indicated)										
Financial data										
Prescriptions dispensed (in thousands)	37,826		3,851	10.2%	41,677		(2,465)	(5.9)%	39,212	
Revenue per prescription dispensed	$ 47.31		$ 1.12	2.4%	$ 48.43		$ (3.44)	(7.1)%	$ 44.99	
Gross profit per prescription dispensed	$ 6.21		$ 0.68	10.9%	$ 6.89		$ 0.55	8.0%	$ 7.44	
Institutional pharmacy gross margin	13.1%		1.1%	8.3%	14.2%		2.3%	16.2%	16.5%	
Generic dispensing rate *	76.5%		3.1%	4.1%	79.6%		3.7%	4.6%	83.3%	
Customer licensed beds under contract										
Beginning of period	313,364		47,790	15.2%	361,154		(23,941)	(6.6)%	337,213	
Additions	95,949		(65,489)	(68.3)	30,460		(9,262)	(30.4)%	21,198	
Losses	(48,159)		(6,242)	(13.0)%	(54,401)		2,998	5.5%	(51,403)	
End of period	361,154		(23,941)	(6.6)%	337,213		(30,205)	(9.0)%	307,008	
Hospital Management (in whole numbers except where indicated)										
Volume information										
Hospital management contracts serviced	90		1	1.1%	91		(2)	(2.2)%	89	

* Single source generic drugs, previously classified as brand drugs, are now being classified as generics for purposes of the generic dispensing rate calculation in all periods.

Revenues

Institutional pharmacy revenues decreased $254.3 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 due to the net decline in customer licensed beds under contract of 30,205 as well as other factors including the continued wave of drugs converting from brand to generic which results in lower revenues. The decrease of $254.3 million is comprised of an unfavorable volume variance of approximately $119.4 million or 2,465,000 less prescriptions dispensed and an unfavorable rate variance of approximately $134.9 million or $3.44 decrease per prescription dispensed. The rate variance was comprised of an increase of approximately $65.0 million due to inflation on brand name drugs dispensed between periods offset by reduced reimbursement rates on generics and certain pricing concessions and a decrease of approximately $199.9 million due to the increase in the generic dispensing rate from 79.6% to 83.3%.

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The increase in hospital management and other revenues of $5.8 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 was due to primarily to the acquisition of Amerita, Inc. (Amerita) in the fourth quarter 2012 and an overall increase in pass through costs partially offset by two less hospitals serviced during the period.

Institutional pharmacy revenues increased $229.2 million for the year ended December 31, 2011 compared to the year ended December 31, 2010, due to the Chem Rx and other pharmacy acquisitions. The increase of $229.2 million resulted from a favorable volume variance of approximately $182.2 million or 3,851,000 additional prescriptions dispensed and a favorable rate variance of approximately $47.0 million or $1.12 increase per prescription dispensed. The rate variance was comprised of approximately $204.3 million due to inflation on drugs dispensed between periods offset by $157.3 million due to the increase in the generic dispensing rate from 76.5% to 79.6% and certain pricing concessions. The favorable volume variance of approximately $182.2 million was due to the increase in customer licensed beds under contract as a result of the acquisitions.

The increase in hospital management and other revenues of $4.6 million for the year ended December 31, 2011 compared to the year ended December 31, 2010 was primarily due to an increase in the number of hospital management contracts serviced.

Cost of Goods Sold

Institutional pharmacy cost of goods sold decreased $258.9 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 primarily due to a decrease in overall total drug costs associated with fewer prescriptions dispensed and certain brand-name drugs that recently went generic. The decrease of $258.9 million is comprised of a volume variance of $102.4 million and a rate variance of $156.5 million. The drug costs as a percentage of revenue decreased 375 bps as a result of rebates and the brand to generic conversions. Other costs included in cost of goods sold decreased in overall dollars but increased as a percentage of revenues 145 bps, of which the increase primarily related to salaries and wages expense, employee benefits and delivery fees as a percentage of revenues increasing 71 bps, 32 bps and 15 bps, respectively, along with other smaller increases in various items.

The increase in hospital management and other cost of goods sold of $5.1 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 was due primarily to the acquisition of Amerita and the overall increase in pass through costs partially offset by two less hospitals serviced during the period.

Institutional pharmacy cost of goods sold increased $177.0 million for the year ended December 31, 2011 compared to the year ended December 31, 2010 primarily due to the Chem Rx and other pharmacy acquisitions. Overall total drug costs decreased as a percent of revenues 114 bps due primarily to higher rebates on generic drugs as a result of the Amended Prime Vendor Agreement and implementation of changes in branded pharmaceutical purchasing practices. Other costs included in cost of goods sold increased as a percentage of revenues 4 bps.

Hospital management and other cost of goods sold increased $4.4 million for the year ended December 31, 2011 as compared to the year ended December 31, 2010 due to the additional hospital management contract serviced during the period.

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Gross Profit and Operating Expenses

Gross profit and other operating expenses were the following for the periods presented (dollars in millions):

	Years Ended December 31,									
	2010		Increase (Decrease)		2011		Increase (Decrease)		2012	
	Amount	% of Revenues			Amount	% of Revenues			Amount	% of Revenues
Gross profit and operating expenses:										
Total gross profit	$ 242.5	13.1%	$ 52.4	21.6%	$ 294.9	14.2%	$ 5.3	1.8%	$ 300.2	16.4%
Selling, general and administrative expenses	182.8	9.9	33.7	18.4	216.5	10.4	(1.8)	(0.8)	214.7	11.7
Amortization expense	9.3	0.5	1.7	18.3	11.0	0.5	1.3	11.8	12.3	0.7
Impairment of intangible assets			5.1	100.0	5.1	0.3	(5.1)	(100.0)		
Merger, acquistition, integration costs and other charges	14.6	0.8	0.7	4.8	15.3	0.8	4.6	30.1	19.9	1.1
Hurricane Sandy disaster costs							4.5	100.0	4.5	0.2
Interest expense, net	3.6	0.2	5.2	144.4	8.8	0.4	1.2	13.6	10.0	0.6
Income before provision for income taxes	32.2	1.7	6.0	18.6	38.2	1.8	0.6	1.6	38.8	2.1
Provision for income taxes	13.0	0.7	1.8	13.8	14.8	0.7	1.1	7.4	15.9	0.9
Net income	$ 19.2	1.0%	$ 4.2	21.9%	$ 23.4	1.1%	$ (0.5)	(2.1)%	$ 22.9	1.2%

Institutional pharmacy gross profit for the year ended December 31, 2012 was $291.8 million or $7.44 per prescription dispensed compared to $287.2 million or $6.89 per prescription dispensed for the year ended December 31, 2011. Institutional pharmacy gross profit margin for the year ended December 31, 2012 was 16.5% compared to 14.2% for the year ended December 31, 2011. Institutional pharmacy gross profit margin was positively impacted by higher margins on certain brand-name drugs that recently went generic, decreases in overall drug costs and higher rebates as a percent of revenues.

Institutional pharmacy gross profit for the year ended December 31, 2011 was $287.2 million or $6.89 per prescription dispensed compared to $235.0 million or $6.21 per prescription dispensed for the year ended December 31, 2010. Institutional pharmacy gross profit margin for the year ended December 31, 2011 was 14.2% compared to 13.1% for the year ended December 31, 2010. Gross profit margin was positively impacted by higher margins on drugs which recently became available as generics, better pricing terms as a result of the Amended Prime Vendor Agreement, and implementation of changes in branded pharmaceutical purchasing practices. The increase in gross profit dollars was as a result of these factors as well as the Chem Rx and other pharmacy acquisitions.

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Selling, General and Administrative Expenses (Dollars in millions)

	Years Ended December 31,									
	2010		Increase (Decrease)		2011		Increase (Decrease)		2012	
	Amount	% of Revenues			Amount	% of Revenues			Amount	% of Revenues
Selling, general and administrative expenses										
Total wages, benefits and contract labor	$ 92.3	5.0%	$ 18.0	19.5%	$ 110.3	5.3%	$ (1.3)	(1.2)%	$ 109.0	5.9%
Contracted services	15.1	0.8	(0.1)	(0.7)	15.0	0.7	0.8	5.3	15.8	0.9
Provision for doubtful accounts	18.5	1.0	6.3	34.1	24.8	1.2	0.4	1.6	25.2	1.4
Supplies	6.7	0.4	0.1	1.5	6.8	0.3	(0.4)	(5.9)	6.4	0.3
Travel expenses	5.0	0.3	0.1	2.0	5.1	0.2	(0.1)	(2.0)	5.0	0.3
Professional fees	8.6	0.5	4.7	54.7	13.3	0.6	(2.3)	(17.3)	11.0	0.6
Adjudication	3.1	0.2	1.0	32.3	4.1	0.2	(0.9)	(22.0)	3.2	0.2
Stock-based compensation	4.8	0.3	1.1	22.9	5.9	0.3	0.8	13.6	6.7	0.4
Depreciation	10.0	0.5	(0.2)	(2.0)	9.8	0.5	(0.3)	(3.1)	9.5	0.5
Rent	4.5	0.2	0.3	6.7	4.8	0.2	(0.1)	(2.1)	4.7	0.3
Maintenance	2.6	0.1	0.3	11.5	2.9	0.1	0.5	17.2	3.4	0.2
Other costs	11.6	0.6	2.1	18.1	13.7	0.8	1.1	8.0	14.8	0.7
Total selling, general and administrative expenses	$ 182.8	9.9%	$ 33.7	18.4%	$ 216.5	10.4%	$ (1.8)	(0.8)%	$ 214.7	11.7%

Selling, general and administrative expenses decreased $1.8 million for the year ended December 31, 2012, compared to the year ended December 31, 2011. The decrease of $1.8 million is due primarily to decreases of $2.3 million in professional fees and $1.3 million in labor costs as a result of a realignment of certain overhead functions, partially offset by an increase of $0.8 million in both contracted services and stock-based compensation. All other costs included in selling, general and administrative expenses increased approximately $0.2 million.

Selling, general and administrative expenses increased $33.7 million for the year ended December 31, 2011, compared to the year ended December 31, 2010. The increase of $33.7 million is primarily due to higher labor costs of $18.0 million. The labor increase of $18.0 million included $10.9 million of performance based compensation. Bad debt expense increased $6.3 million primarily as a result of the Chem Rx and other pharmacy acquisitions and professional fees increased $4.7 million. All other costs included in selling, general and administrative expenses increased approximately $4.7 million as a result of the acquisitions.

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Depreciation and Amortization

Depreciation expense for the periods presented is as follows (dollars in millions):

	Years Ended December 31,					
	2010		2011		2012	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Leasehold improvements	$ 1.7	0.1%	$ 1.9	0.1%	$ 1.6	0.1%
Equipment and software	16.4	0.9	17.4	0.9	16.7	0.9
Leased equipment	0.7	NM	0.8	NM	0.3	NM
Total depreciation expense	$ 18.8	1.0%	$ 20.1	1.0%	$ 18.6	1.0%
Depreciation expense recorded in cost of goods sold	$ 8.8	0.5%	$ 10.3	0.5%	$ 9.1	0.5%
Depreciation expense recorded in selling, general & administrative expenses	10.0	0.5	9.8	0.5	9.5	0.5
Total depreciation expense	$ 18.8	1.0%	$ 20.1	1.0%	$ 18.6	1.0%
Total capital expenditures	$ 12.6	0.7%	$ 13.2	0.6%	$ 20.8	1.1%

Depreciation expense decreased $1.5 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 as a result of certain equipment and leasehold improvements becoming fully depreciated in 2011 and having no expense in 2012. Additionally, there was a decrease in depreciation on leased equipment of $0.5 million as a result of the capital lease expiration in the first half of 2012.

Depreciation expense increased $1.3 million for the year ended December 31, 2011 compared to the year ended December 31, 2010, primarily as a result of a full year of depreciation for the Chem Rx acquisition and the acquisition of Lone Star Pharmacy LTD, a Texas Limited partnership, and Pharmastat Transport, LTD, a Texas limited partnership (collectively, Lone Star).

Amortization expense related to certain identifiable intangibles for the periods presented is as follows (dollars in millions):

	Years Ended December 31,					
	2010		2011		2012	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Trade names	$ 1.5	0.1%	$ 1.6	0.1%	$ 1.7	0.1%
Non-compete agreements	1.8	0.1	1.9	0.1	2.4	0.2
Customer relationships	6.0	0.3	7.5	0.3	8.2	0.4
Total amortization expense	$ 9.3	0.5%	$ 11.0	0.5%	$ 12.3	0.7%

Amortization expense increased $1.3 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 as a result of amortization expense recognized primarily on customer relationships acquired through the 2011 Acquisitions. Additionally, more expense was recognized in 2012 compared to 2011 related to short-term non-compete agreements which began in the current year.

Amortization expense increased $1.7 million for the year ended December 31, 2011 compared to the year ended December 31, 2010, primarily as a result of a full year of amortization associated with intangibles acquired in the Chem Rx and Lone Star acquisitions.

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Impairment of intangible assets

During the third quarter of 2011, the Corporation recorded a pre-tax impairment charge of $5.1 million related to finite-lived customer relationships. The impairment incurred was the result of non-renewal of certain customer contracts. The impairment was related to intangible assets acquired in an acquisition during the year ended December 31, 2005. These asset groups were assessed for recoverability and management determined the finite-lived customer relationship assets to be impaired. No other assets within the asset groups were deemed impaired. Using a discounted cash flow analysis, the Corporation determined that the pre-tax impairment charge of $5.1 million was required to write the carrying value down to fair value, resulting in a loss per diluted share impact of $0.11. The Corporation recognized the impairment as a permanent write-down of the cost basis and accumulated amortization of the affected assets.

Merger, Acquisition, Integration Costs and Other Charges (Dollars in millions, except per share amounts)

	Years Ended December 31,		
	2010	2011	2012
Merger, integration costs and other charges:			
Pre-Pharmacy transaction litigation matters	$ 5.0	$ (2.0)	$
IT Transition costs			3.0
Tender offer costs		2.8	1.9
Professional and advisory fees	2.3	0.9	3.2
General and administrative	0.7	0.1	
Employee costs	0.5	0.2	0.2
Severance costs	0.6	0.2	0.1
Facility costs	0.3	0.2	0.8
	9.4	2.4	9.2
Acquisition related costs:			
Professional and advisory fees	3.5	4.9	7.7
General and administrative	1.5	0.8	0.2
Employee costs	0.4	2.9	2.4
Severance costs		1.7	(0.3)
Facility costs	1.3	1.7	0.6
Contingent consideration	(1.7)		
Other	0.2	0.9	0.1
	5.2	12.9	10.7
Total merger, acquisition, integration costs and other charges	$ 14.6	$ 15.3	$ 19.9
Negative effect on diluted earnings per share	$ (0.29)	$ (0.32)	$ (0.40)

The Corporation incurred integration costs and other charges during the year ended December 31, 2012 related to costs incurred as a result of Omnicare s unsolicited tender offer including legal, investment banking and other fees along with other costs related to costs to convert data and integrate systems. During the years ended December 31, 2011 and December 31, 2012, $2.8 million and $1.9 million, respectively, of tender offer costs were incurred. The Corporation does not anticipate that any additional tender offer costs will be incurred as the tender offer expired on February 21, 2012.

Integration costs increased $6.8 million for the year ended December 31, 2012 compared to the year ended December 31, 2011 due primarily to the reversal of an estimated liability in 2011. During the second quarter of 2010, the Corporation recorded an estimated liability of $5.0 million related to certain claims arising from time periods prior to July 31, 2007. During the third quarter of 2011, the Corporation was informed that one claim would not be pursued. Therefore, the Corporation reversed $2.0 million of the estimated liability. In addition, the Corporation incurred costs and other charges of $3.0 million in 2012 related to the IT Transition.

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Acquisition costs decreased $2.2 million for the year ended December 31, 2012 compared to the year ended December 31, 2011.

Acquisition and related costs were higher for the year ended December 31, 2011 compared to the year ended December 31, 2010 due to the continuing costs associated with the Chem Rx acquisition. In addition, professional and advisory fees were higher as a result of the 2011 acquisitions and other pipeline acquisition opportunities.

In the year ended December 31, 2010 the Corporation concluded a contingent consideration of $1.7 million was not met and therefore reversed the liability. The contingent consideration represented a future earn-out associated with our acquisition of an institutional pharmacy business based in West Virginia. The liability was relieved as of December 31, 2010 when it became apparent the contingent consideration would not be paid. The Corporation assessed the fair value of the liability through the date of determination which was August 10, 2012 when it was concluded that the gross profit requirement for the payout of the contingent consideration was not met.

Hurricane Sandy disaster costs

In October 2012, Hurricane Sandy caused significant damage on Long Island, New York and surrounding areas. The financial impacts of the storm to the Corporation s Long Beach facility (Long Beach) as well as damage and disruption at our customers facilities included lower revenue estimated at $8.6 million due to the inability to operate at full capacity during the recovery period. In addition, the Corporation has incurred actual losses as follows for the year ended December 31, 2012 (dollars in millions):

Fixed assets	$ 1.6
Excess operating costs	1.4
Inventory	1.3
Contractual and bad debt expense	1.0
Business continuation	0.8
Restoration	0.5
Professional fees	0.2
Employee costs	0.1
Insurance recoverable	(2.4)
Total net costs associated with Hurricane Sandy	$ 4.5
Negative effect on diluted earnings per share	$ (0.09)

The Corporation expects a portion of the cost associated with Hurricane Sandy to be covered by insurance. While the exact amount has not been determined, the Corporation s current estimate of covered losses, net of its $1.0 million deductible, is approximately $2.4 million. After consideration of a $1.0 million advance by the insurance carrier the Corporation has recorded a receivable for $1.4 million which is included in prepaids and other assets in the consolidated balance sheet. The actual recovery will vary depending on the outcome of the insurance loss adjustment process. Accordingly, no offsetting benefit for insurance recoveries above the amount of the loss shown in the 2012 results was recorded. Additionally, the Corporation allocated $1.4 million of certain operating costs and $1.0 million in bad debt expense and contractual revenue adjustments, associated with lost business and customers to Hurricane Sandy disaster costs in the consolidated income statement.

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Interest Expense (Dollars in millions)

	Years Ended December 31,		
	2010	2011	2012
Interest expense:			
Term Debt	$ 2.8	$ 6.0	$ 7.4
Revolving Credit Facility	0.4	2.0	1.6