Premier, Inc.
Form 10-K
August 23, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K
ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For The Fiscal Year Ended June 30, 2017
Commission File Number 001-36092
Premier, Inc.
(Exact name of registrant as specified in its charter)

Delaware	35-2477140
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
13034 Ballantyne Corporate Place Charlotte, North Carolina	28277
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (704) 357-0022

Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Class A Common Stock, $0.01 Par Value	NASDAQ Global Select Market

Securities Registered Pursuant to Section 12(g) of the Act: None
Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No o
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 o No x
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 x No o
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 during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes x No o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) 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. x
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	x	Accelerated filer	o	Non-accelerated filer (Do not check if a smaller reporting company)	o
Smaller reporting company	o	Emerging growth company	o		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. o

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

The aggregate market value of the Class A common stock held by non-affiliates of the Registrant as of the last business day of the Registrant's most recently completed second fiscal quarter was approximately $1,501.1 million. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates.

As of August 18, 2017, there were 53,217,113 shares of the Registrant's Class A common stock, par value $0.01 per share, outstanding and 86,067,478 shares of the Registrant's Class B common stock, par value $0.000001 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The Registrant's definitive proxy statement for its 2017 Annual Meeting of Stockholders to be held on or about December 1, 2017 are incorporated by reference into Part III hereof to the extent described herein.

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EXPLANATORY NOTE

This report represents the annual report for the fiscal year ended June 30, 2017 for Premier, Inc. (this "Annual Report"). On October 1, 2013, Premier, Inc. completed the initial public offering ("IPO") of its Class A common stock (the "Class A common stock"). Premier, Inc. is a holding company that was incorporated as a Delaware corporation on May 14, 2013 which, prior to the IPO, had no substantial assets and conducted no substantial activity except in connection with the IPO. Premier, Inc.'s primary asset is a controlling equity interest in Premier Services, LLC, a Delaware limited liability company ("Premier GP"). Premier GP is the sole general partner of Premier Healthcare Alliance, L.P. ("Premier LP"), a California limited partnership. Premier, Inc. conducts substantially all of its business operations through Premier LP and its other consolidated subsidiaries. Unless the context suggests otherwise, references in this Annual Report to "Premier," the "Company," "we," "us" and "our" refer to Premier, Inc. and its consolidated subsidiaries.

Throughout this Annual Report, references to (1) "members" refer collectively to our past, present and future customers and (2) "member owners" refer collectively to our past, present and future members, who have owned, or who currently own, limited partnership interests in Premier LP, and beneficially own shares of Premier, Inc. Class B common stock, (the "Class B common stock"), and Class B common units of Premier LP (the "Class B common units"), provided, that, in the context of discussions of the group purchasing organization ("GPO") participation agreements throughout this Annual Report, the term "member owner" also includes any related entity or affiliate of a member owner that is approved by Premier LP to be the signatory of such GPO participation agreement in lieu of the member owner.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Statements made in this Annual Report that are not statements of historical or current facts, such as those under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations," are "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements may involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance or achievements to be materially different from historical results or from any future results or projections expressed or implied by such forward-looking statements. In addition to statements that explicitly describe such risks and uncertainties, readers are urged to consider statements in conditional or future tenses or that include terms such as "believes," "belief," "expects," "estimates," "intends," "anticipates" or "plans" to be uncertain and forward-looking. Forward-looking statements may include comments as to our beliefs and expectations regarding future events and trends affecting our business and are necessarily subject to uncertainties, many of which are outside our control. Factors that could cause actual results to differ materially from those indicated in any forward-looking statement include, but are not limited to:

- competition which could limit our ability to maintain or expand market share within our industry;
- consolidation in the healthcare industry;
- potential delays recognizing or increasing revenue if the sales cycle or implementation period takes longer than expected;
- the terminability of member participation in our group purchasing organization programs ("GPO") with limited or no notice, or the failure of a significant number of members to renew their GPO participation agreements;
- the rate at which the markets for our non-GPO services and products develop;
- the dependency of our members on payments from third-party payers;
- our reliance on administrative fees, which we receive from GPO suppliers;
- our ability to maintain third-party provider and strategic alliances or enter into new alliances;
- our ability to timely offer new and innovative products and services;
- the portion of revenues we receive from our largest members;
- risks and expenses related to future acquisition opportunities and integration of acquisitions;
- financial and operational risks associated with investments in, or partnerships or joint ventures with, other businesses, particularly those that we do not control;
- potential litigation;
- our reliance on Internet infrastructure, bandwidth providers, data center providers and other third parties and our own systems for providing services to our users;
- data loss or corruption due to failures or errors in our systems and service disruptions at our data centers, or breaches or failures of our security measures;
- the financial, operational and reputational consequences of cyber-attacks or other data security breaches that disrupt our operations or result in the dissemination of proprietary or confidential information about us or our members or other third parties;
- our ability to use, disclose, de-identify or license data and to integrate third-party technologies;
- our use of "open source" software;
- changes in industry pricing benchmarks;
- our inability to grow our integrated pharmacy business or maintain current patients due to increases in the safety risk profiles of prescription drugs or the withdrawal of prescription drugs from the market, or our inability to maintain and expand our existing base of drugs in our integrated pharmacies;
- our dependency on contract manufacturing facilities located in various parts of the world;
- our ability to attract, hire, integrate and retain key personnel;

- adequate protection of our intellectual property and potential claims against our use of the intellectual property of third parties;
- potential sales and use tax liability in certain jurisdictions;
- changes in tax laws that materially impact our tax rate, income tax expense, cash flows or tax receivable agreement ("TRA") liabilities;
- our indebtedness and our ability to obtain additional financing on favorable terms;
- fluctuation of our quarterly cash flows, revenues and results of operations;
- changes and uncertainty in the political, economic or regulatory environment affecting healthcare organizations, including with respect to the status of the Patient Protection and Affordable Care Act, as amended by the Healthcare and Education Reconciliation Act of 2010, collectively referred to as the "ACA";
- our compliance with complex federal and state laws governing financial relationships among healthcare providers and the submission of false or fraudulent healthcare claims;
- interpretation and enforcement of current or future antitrust laws and regulations;
- compliance with complex federal and state privacy, security and breach notification laws;
- compliance with current or future laws, rules or regulations adopted by the Food & Drug Administration ("FDA") applicable to our software applications that are considered medical devices;
- compliance with, and potential changes to, extensive federal, state and local laws, regulations and procedures governing our integrated pharmacy operations;
- risks inherent in the filling, packaging and distribution of pharmaceuticals, including the counseling required to be provided by our pharmacists for dispensing of products;
- our holding company structure and dependence on distributions from Premier Healthcare Alliance, L.P. ("Premier LP");
- different interests among our member owners or between us and our member owners;
- the ability of our member owners to exercise significant control over us, including through the election of all of our directors;
- exemption from certain corporate governance requirements due to our status as a "controlled company" within the meaning of the NASDAQ rules;
- the terms of agreements between us and our member owners;
- payments made under the TRAs to Premier LP's limited partners and our ability to realize the expected tax benefits related to the acquisition of Class B common units from Premier LP's limited partners;
- changes to Premier LP's allocation methods or examinations or changes in interpretation of applicable tax laws and regulations by various taxing authorities that may increase a tax-exempt limited partner's risk that some allocated income is unrelated business taxable income;
- provisions in our certificate of incorporation and bylaws and the Amended and Restated Limited Partnership Agreement of Premier LP (as amended, the "LP Agreement") and provisions of Delaware law that discourage or prevent strategic transactions, including a takeover of us;
- failure to maintain an effective system of internal controls;
- the number of shares of Class A common stock that will be eligible for sale or exchange in the near future and the dilutive effect of such issuances;
- our intention not to pay cash dividends on our Class A common stock;
- possible future issuances of common stock, preferred stock, limited partnership units or debt securities and the dilutive effect of such issuances; and
- the risk factors discussed under the heading "Risk Factors" in Item 1A herein.

More information on potential factors that could affect our financial results is included from time to time in the "Cautionary Note Regarding Forward-Looking Statements," "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" or similarly captioned sections of this Annual Report and our other periodic and current filings made from time to time with the Securities and Exchange Commission ("SEC"), which are available on our website at http://investors.premierinc.com/. You should not place undue reliance on any of our forward-looking statements which speak only as of the date they are made. We undertake no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Furthermore, we cannot guarantee future results, events, levels of activity, performance or achievements.

Market Data and Industry Forecasts and Projections

We use market data and industry forecasts and projections throughout this Annual Report and in particular, under Item 1. Business. We have obtained the market data from certain publicly available sources of information, including industry publications. We believe the data others have compiled are reliable, but we have not independently verified the accuracy of this information. While we are not aware of any misstatements regarding the industry data presented herein, forecasts and projections involve risks and uncertainties and are subject to change based on various factors, including those discussed under Item 1A. Risk Factors of this Annual Report. You should not place undue reliance on any such market data or industry forecasts and projections. We undertake no obligation to publicly update or revise any such market data or industry forecasts and projections, whether as a result of new information, future events or otherwise.

Trademarks, Trade Names and Service Marks

This Annual Report includes trademarks, trade names and service marks that we either own or license, such as "Acro Pharmaceutical Services," "Aperek," "CECity," "Commcare," "Essensa," "Healthcare Insights," "Innovatix," "Meddius," "MEMdata," "Premier," "PremierConnect," "PremierPro," "Premier REACH," "ProviderSelect MD," "QUEST" and "SYMMEDrx," which are protected under applicable intellectual property laws. Solely for convenience, trademarks, trade names and service marks referred to in this Annual Report may appear without the ®, ™ or ℠ symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the right of the applicable licensor to these trademarks, trade names and service marks. This Annual Report also may contain trademarks, trade names and service marks of other parties, and we do not intend our use or display of other parties' trademarks, trade names or service marks to imply, and such use or display should not be construed to imply, a relationship with, or endorsement or sponsorship of us by, these other parties.

PART I

Item 1. Business

The following discussion should be read in conjunction with our audited consolidated financial statements and accompanying notes thereto included elsewhere in this Annual Report on Form 10-K. The following discussion includes certain forward-looking statements. For a discussion of important factors, including the continuing development of our business and other factors which could cause actual results to differ materially from the results referred to in the historical information and the forward-looking statements presented herein, see "Item 1A. Risk Factors" and "Cautionary Note Regarding Forward-Looking Statements" contained in this Annual Report.

Our Company

Premier, Inc., incorporated in Delaware on May 14, 2013, is primarily owned by hospitals, health systems and other healthcare organizations (such owners of Premier are referred to herein as "member owners") located in the United States, as well as public stockholders. Together with our subsidiaries and affiliates, we are a leading healthcare improvement company, uniting an alliance of approximately 3,900 U.S. hospitals and health systems and approximately 150,000 other providers and organizations to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. We believe that we play a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. We deliver value through a comprehensive technology-enabled platform that offers critical supply chain services, clinical, financial, operational and population health software-as-a-service ("SaaS") informatics products, advisory services and performance improvement collaborative programs.

As of June 30, 2017, we were controlled by 169 U.S. hospitals, health systems and other healthcare organizations that represent 1,425 owned, leased and managed acute care facilities and other non-acute care organizations. All of our Class B common stock was held beneficially by our member owners and all of our Class A common stock was held by public investors, which may include member owners that have received shares of our Class A common stock in connection with previous quarterly exchanges pursuant to an exchange agreement (the "Exchange Agreement") entered into by the member owners (see Note 1 - Organization and Basis of Presentation to the accompanying audited consolidated financial statements for more information).

As a member-owned healthcare alliance, our mission, products and services, and long-term strategy have been developed in partnership with our member hospitals, health systems and other healthcare organizations. We believe that this partnership-driven business model creates a relationship between our members and us that is characterized by aligned incentives and mutually beneficial collaboration. This relationship affords us access to critical proprietary data and encourages member participation in the development and introduction of new Premier products and services. Our interaction with our members provides us with a window into the latest challenges confronting the industry we serve and innovative best practices that we can share broadly within the healthcare industry, including throughout our membership. This model has enabled us to develop size and scale, data and analytics assets, expertise and customer engagement required to accelerate innovation, provide differentiated solutions and facilitate growth.

We seek to address challenges facing healthcare delivery organizations through our comprehensive suite of solutions that we believe:

- improve the efficiency and effectiveness of the healthcare supply chain;
- deliver improvement in cost, quality and safety;
- innovate and enable success in emerging healthcare delivery and payment models to manage the health of populations; and
- utilize data and analytics to drive increased connectivity, and clinical, financial and operational improvement.

Our business model and solutions are designed to provide our members with access to scale efficiencies, spread the cost of their development, derive intelligence from our anonymized data provided by our members in our data warehouse, mitigate the risk of innovation and disseminate best practices that will help our member organizations succeed in their transformation to higher quality and more cost-effective healthcare.

We deliver our integrated platform of solutions that address the areas of total cost management, quality and safety improvement and population health management and manage our business through two reportable business segments:

Supply Chain Services and Performance Services. The Supply Chain Services segment includes our GPO, integrated pharmacy offerings and direct

sourcing activities. The Performance Services segment includes our SaaS informatics products, collaboratives, advisory services, government services and insurance management services businesses.

Industry Overview

According to data from the Centers for Medicare & Medicaid Services, or CMS, healthcare expenditures are a large component of the U.S. economy and are expected to grow by an average of 5.6% per year for the period 2015-2025, reaching 19.9% of gross domestic product, or GDP, by 2025. According to data from the 2014 American Hospital Association's Annual Survey, published in the 2016 edition of the AHA Hospital Statistics™, there were approximately 5,000 U.S. community hospitals with approximately 786,900 staffed beds in the United States. Of these acute care facilities, approximately 3,200 were part of either multi-hospital or diversified single hospital systems, meaning they were owned, leased, sponsored or contract managed by a central organization. According to the May 2016 edition of IMS Health's Healthcare Market Index, in addition to U.S. hospitals, there were approximately 520,000 alternate site facilities and providers across the continuum of care in the United States. These alternate site facilities include primary/ambulatory care and post-acute care providers. Increasingly, these alternate site facilities are being acquired by, integrated into or aligned with acute care facilities creating integrated delivery networks.

Healthcare Supply Chain Services Industry

According to CMS data, total spending on hospital services in the United States is projected to be approximately $1.1 trillion, or approximately 32% of total healthcare expenditures, in 2017. Expenses associated with the hospital supply chain, such as supplies and operational and capital expenditures, typically represent between 20% and 30% of a hospital's budget according to Booz & Company. With continued reimbursement rate pressure across government and managed care payers, a transitioning payment model from fee-for-service to value-based payment, and national health expenditures representing a significant portion of the economy, healthcare providers are examining all sources of cost savings, with supply chain spending a key area of focus. We believe opportunities to drive cost out of the healthcare supply chain include improved pricing for medical supplies and pharmaceuticals, appropriate resource utilization and increased operational efficiency.

From origination at the supplier to final consumption by the provider or patient, healthcare products pass through an extensive supply chain incorporating manufacturers, distributors, GPOs, pharmacy benefit managers, and retail, long-term care and integrated pharmacies, among others. In response to the national focus on health spending and managing healthcare costs, supply chain participants are seeking more convenient and cost-efficient ways to deliver products to patients and providers. We believe that improvements to the healthcare supply chain to bring it on par with other industries that have more sophisticated supply chain management can drive out significant inefficiencies and cost.

Healthcare Performance Services Industry

Legislative reform, unsustainable cost trends, and the need for improved quality and outcomes have generated greater focus among healthcare providers on cost management, quality and safety, and population health management. In 2015, the Department of Health and Human Services (HHS) announced its goals for aligning future Medicare payments with quality and value, including tying 85 and 90 percent of Medicare fee-for-service payments to performance in 2016 and 2018, respectively, and shifting up to 50 percent of Medicare fee-for-service payments to alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements by the end of 2018. Even with the possibility of the ACA's repeal, replacement or modification, we expect this trend to continue. In order to meet these goals, health systems will need to continually monitor performance and manage costs, while demonstrating high levels of quality and implementing new care delivery models. In response to this dynamic environment, we expect the markets for performance services and solutions in the areas of cost management, quality and safety and population health management to continue to grow.

We expect information technology to continue to play a key enabling role in workflow efficiency and cost reduction, performance improvement and care delivery transformation across the healthcare industry. In particular, the trends toward value-based payment models and population-based healthcare require more sophisticated business intelligence, expanded data sets and technology solutions. To achieve higher-quality outcomes and control total cost of care, providers exhibit a strong and continuing need for more comprehensive data and analytic capabilities to help them understand their current performance, identify opportunities for improvement and manage population health risk. We

expect demand for data management and data analytics products to complement the focus on electronic health record adoption. According to Frost and Sullivan, 50% of hospitals in the United States are expected to adopt data analytics capabilities by 2016, up from 10% in 2011. Similarly, the advisory services business is growing rapidly in the areas of business model strategy and redesign, process improvement, labor productivity, non-labor cost management, clinical integration and change management.

Our Membership

Our current membership base includes many of the country's most progressive and forward-thinking healthcare organizations. The participation of these organizations in our membership provides us with a window into the latest challenges confronting the industry we serve and innovative best practices that we can share broadly throughout our membership. We continually seek to add new members that are at the forefront of innovation in the healthcare industry. At June 30, 2017, our members included approximately 3,900 U.S. hospitals and health systems and approximately 150,000 other providers and organizations. Approximately 380 individuals, representing approximately 195 of our U.S. hospital members, sit on 22 of our strategic and sourcing committees, and as part of these committees, use their industry expertise to advise on ways to improve the development, quality and value of our products and services. In addition, ten senior executives from our U.S. hospital member owner systems currently serve on our Board of Directors. Other than GNYHA Services, Inc. ("GNYHA") and its member organizations, which accounted for 7%, 9% and 9% of our net revenue in the fiscal years ended June 30, 2017, 2016 and 2015, respectively, no individual member or member owner systems accounted for more than 5% of our net revenue in such periods. Total GPO purchasing volume by all members participating in our GPO was approximately $56 billion and $48 billion for the calendar years 2016 and 2015, respectively.

The following table sets forth certain information with respect to retention rates for members participating in our GPO in the Supply Chain Services segment and renewal rates for our SaaS informatics products subscriptions in the Performance Services segment for the fiscal years shown:

	Year Ended June 30,			
	2017	2016	2015	3 Year Average
GPO retention rate [(a)]	99%	97%	99%	98%
SaaS institutional renewal rate [(b)]	95%	92%	94%	94%

(a) The retention rate is calculated based upon the aggregate purchasing volume among all members participating in our GPO for such fiscal year less the annualized GPO purchasing volume for departed members for such fiscal year, divided by the aggregate purchasing volume among all members participating in our GPO for such fiscal year.

(b) The renewal rate is calculated based upon the total number of members that have SaaS revenue in a given period that also have revenue in the corresponding prior year period divided by the total number of members that have SaaS revenue in the same period of the prior year.

Our Business Segments

We deliver our integrated platform of solutions that address the areas of total cost management, quality and safety improvement and population health management and manage our business through two business segments: Supply Chain Services and Performance Services, as addressed in Note 21 - Segments to the audited consolidated financial statements of this Annual Report. We have no significant foreign operations or revenues.

Supply Chain Services

Our Supply Chain Services segment assists our members in managing their non-labor expense and capital spend through a combination of products, services and technologies, including one of the largest national healthcare GPOs in the United States serving acute and alternate sites, integrated pharmacy offerings and direct sourcing activities. Membership in our GPO also provides access to certain SaaS informatics products related to the supply chain and the opportunity to participate in our ASCEND® collaborative. Our Supply Chain Services segment consists of the following products and solutions:

Group Purchasing. Our national portfolio of approximately 2,300 contracts with approximately 1,300 suppliers provides our members with access to a wide range of products and services, including medical and surgical products, pharmaceuticals, laboratory supplies, capital equipment, information technology, facilities and construction, food and nutritional products and purchased services (such as clinical engineering and document shredding services). We use our members' aggregate purchasing power to negotiate pricing discounts and improved contract terms with suppliers. Contracted suppliers pay us administrative fees based on the purchase volume of goods and services sold to our healthcare provider members under the contracts we have negotiated. We also partner with other organizations, including regional GPOs, to extend our network base to their members.

Our contract portfolio is designed to offer our healthcare provider members a flexible solution comprised of multi-sourced supplier contracts, as well as pre-commitment and/or single-sourced contracts that offer higher discounts. Our multi-sourced contracts offer pricing tiers based on purchasing volume and/or commitment and multiple suppliers for many products and services. Our pre-commitment contracts require that a certain amount of our members commit in advance to a specified amount or percentage of purchasing volume before we enter into a contract with a particular supplier. Our single-source contracts are

entered into with a specified supplier, and through this exclusive relationship, allow us to contract for products that meet our members' specifications. In the case of pre-commitment contracts, we provide the particular supplier with a list of members that have pre-committed to a specified amount or percentage of purchasing volume and the supplier directly handles the tracking and monitoring of fulfillment of such purchasing volume. In the case of single and multi-sourced contracts, we negotiate and execute the contracts with suppliers on behalf of our members and make such contracts available to our members to access. The utilization of such single and multi-sourced contracts is determined by the particular member with assistance from our field force. Since there are no specific fulfillment requirements needed in our single and multi-source contracts in order to obtain certain pricing levels, each particular member and supplier agree on the appropriate pricing tier based on expected purchasing volume with tracking and ongoing validation of such purchasing volume provided by the supplier. The flexibility provided by our expansive contract portfolio allows us to effectively address the varying needs of our members and the significant number of factors that influence and dictate these needs, including overall size, service mix, and the degree of integration between hospitals in a health system.

We continually innovate our GPO programs and supply chain platforms. For example, our GroupBuy program enables coordinated, limited-time, volume-driven purchasing opportunities that offer savings beyond regular contract pricing. Through a proprietary web-based application, we offer our members the opportunity to aggregate committed volumes and achieve additional price discounts while allowing our suppliers to sell targeted products, including time-sensitive or excess inventory, more efficiently and at reduced costs.

Our GPO programs target multiple markets, including acute care and alternate site settings. Our alternate site program, one of the largest in the United States with approximately 150,000 members as of June 30, 2017, includes the following:

Continuum of Care. Alternate sites served by our Continuum of Care GPO program include long-term care and senior living, ambulatory care, first responders and emergency medical services, home health, imaging centers and surgery centers. Our Continuum of Care GPO members have access to nearly all of our GPO supplier contracts, including medical and surgical products, pharmaceuticals, laboratory supplies, facilities and construction, capital equipment, information technology, food and nutritional products and purchased services, as well as additional GPO supplier contracts accessed through our consolidated subsidiaries, Innovatix, LLC ("Innovatix") and Essensa Ventures, LLC ("Essensa"), together one of the nation's largest alternate site GPOs.

ProviderSelect MD®. ProviderSelect MD® is one of the nation's largest group purchasing programs for physicians. Focused specifically on independent physician practices, the program offers members access to nearly all of our GPO supplier contracts.

Premier REACH®. Premier REACH® is a group purchasing program for non-healthcare entities, including education (e.g., K-12 schools, colleges and universities, and early childhood education), hospitality, recreation (e.g., stadiums, parks and fairgrounds) and employee food programs. Our Premier REACH® members have access to nearly all of our GPO supplier contracts including food service, facilities products and services, information technology and administrative services. The Premier REACH® program will be integrated with the Innovatix Business and Industries program that was acquired as part of the acquisition of Innovatix and Essensa on December 2, 2016. The combination of these programs is expected to increase our presence in the non-healthcare marketplace.

Integrated Pharmacy. Through our integrated pharmacy business, we provide a complete service offering for our members to improve access to medication and to better manage patient therapy for chronically-ill patients with specialty drug needs and genetic disorders. Our integrated pharmacy business delivers traditional pharmacy dispensing services (i.e., retail and mail order), as well as “integrated pharmacy” services, which fully integrate the administrative coordination, patient care management, and data management reporting functions that ultimately service the needs of patients, providers, payers, and pharmaceutical manufacturers. The business serves as a scaled solution for our members and to provide an integrated pharmacy “care hub” to meet the unique integrated pharmacy needs of health systems across the continuum of care. We provide robust clinical management programs that are targeted toward those disease states where best-in-class care pathways and interventions by clinically-trained pharmacists are essential for patient adherence and compliance. Our “care hub” capabilities enable members to more effectively care for complex patient populations, improve clinical quality and safety, and harness otherwise

unavailable clinical data.

Direct Sourcing. Our direct sourcing business, SVS, LLC d/b/a S2S Global ("S2S Global"), was established to help our members access a diverse product portfolio and to provide transparency to manufacturing costs and competitive pricing to our members. Through our consolidated subsidiary, S2S Global, we facilitate the development of product specifications with our members, source or contract manufacture the products to member specifications and sell products directly to our members or suppliers. By engaging with our members at the beginning of the sourcing process to define product specifications and then sourcing, or contract manufacturing, products to meet the exact needs of our members, we eliminate the need for

unnecessary product features and specifications that may typically be included by suppliers and result in higher prices for our members without providing incremental value. Therefore, our direct sourcing activities benefit our members by providing them with an expanding portfolio of medical products through more efficient means, and with greater cost transparency, than if such products were purchased from other third-party suppliers. We market our direct sourcing activities under two distinct brands: PremierPro™, which is designated for our members, and Prime Plus™, which is designated for our other customers, primarily regional distributors with private-label product programs.

Managed Services. Our managed services line of business is a fee for service model created to perform supply chain related services for members. Through a partnership with a national pharmacy benefit manager, we provide contract negotiation and administration, claims data and rebate processing and evaluation of current pharmacy formulary and utilization.

SaaS Informatics Products. Members of our GPO have access to certain components of our PremierConnect Supply Chain offering and its associated applications and the ability to purchase additional elements that are discussed in more detail below.

ASCEND® Collaborative. Our ASCEND® Collaborative has developed a process to aggregate purchasing data for our members, enabling such members to determine whether to negotiate committed group purchases within the collaborative. Through our ASCEND® Collaborative, members receive group purchasing programs, tiers and prices specifically negotiated for them, as well as benchmarking metrics to assist them in identifying additional supply chain and operations cost savings opportunities and knowledge sharing with other member participants and industry experts. As of June 30, 2017, approximately 860 U.S. hospital members, which represent approximately 120,000 hospital beds, participated in our ASCEND® Collaborative. These hospital member participants have identified approximately $339.0 million in additional savings as compared to their U.S. hospital peers not participating in ASCEND® since its inception in 2009. For calendar year 2016, these member participants had approximately $16.4 billion in annual supply chain purchasing spend.

Performance Services

Our offerings in the performance services sector of the healthcare industry are primarily information technology analytics and workflow automation and advisory services. We believe we are one of the largest informatics and advisory services businesses in the United States focused on healthcare providers, professional associations, pharmaceutical companies and device manufacturers. Our SaaS informatics products utilize our comprehensive data set to provide actionable intelligence to our members, enabling them to benchmark, analyze and identify areas of improvement across three main categories: cost management, quality and safety, and population health management. This segment also includes our technology-enabled performance improvement collaboratives, through which we convene members, design programs and facilitate, foster and advance the exchange of clinical, financial and operational data among our members to measure patient outcomes and determine best practices that drive clinical, financial and operational improvements. Our Performance Services segment includes our PremierConnect® technology offerings, advisory services, collaboratives, government services and insurance management services, as follows:

PremierConnect®:

We seek to deliver our healthcare cloud applications using an innovative technology foundation that leverages the most recent advances in cloud computing and data management. Our platform allows us to deliver applications that are highly flexible and extendable across healthcare delivery systems. We leverage advanced data science in our informatics applications to help members make smarter cost and quality decisions. We also provide complete packaged integrations and connectors for our cloud-based solutions to operate in conjunction with legacy healthcare IT systems, which substantially reduces time, complexity and cost associated with integrations for our members. PremierConnect is designed to deliver specific functionalities to our members to address existing cost and quality imperatives, help them manage a value-based care reimbursement model and support their regulatory reporting framework. We also provide members optimized web-based communities and research capabilities to capture utilization best practices and clinical surveillance improvement. Our service models allow members to consistently use our resources to inform vital decisions. PremierConnect solutions are organized into five areas: Quality & Regulatory reporting, Clinical Surveillance & Safety, Supply Chain & ERP, Operations and integrated Enterprise

Analytics.

PremierConnect Quality & Regulatory. The PremierConnect Quality & Regulatory domain enables health systems and providers to identify and target high-value quality improvement areas that drive greater clinical effectiveness and efficiency across the continuum of care. This solution provides clinical benchmarking, population analyses and predictive analytics to help hospitals and physician practices be successful in the transition to value-based care.

PremierConnect Clinical Surveillance & Safety. The PremierConnect Clinical Surveillance & Safety domain enables health systems and providers to improve patient safety, including ongoing infection prevention, antimicrobial stewardship, reduction of hospital-acquired conditions and real-time clinical surveillance used to drive faster, more informed decisions.

PremierConnect Supply Chain & ERP. The PremierConnect Supply Chain & ERP domain enables health systems and providers to lower supply chain costs through leading supply chain management analytics, evidence-based purchasing, and innovative enterprise resource planning ("ERP") workflow that drives efficiency and effectiveness throughout the entire procurement life cycle. This healthcare-only ERP solution also extends into accounts payable, general ledger and financial reporting.

PremierConnect Operations. The PremierConnect Operations domain enables health systems and providers to optimize labor management with integrated financial reporting and budgeting across the continuum of care. These applications integrate benchmarking and productivity data from acute, outpatient and ambulatory settings.

PremierConnect® Enterprise Analytics. The PremierConnect Enterprise Analytics domain enables health systems and providers to leverage integrated analytics across all of Premier's subject matter expertise. This solution includes integrating a member's custom data into a hosted and integrated data warehouse and analytics platform. This solution provides data acquisition, management and governance capabilities for health systems and extends this capability to research, life sciences and value-based care programs.

Advisory Services:

Our advisory services, provided through Premier Performance Partners, seek to drive change and improvement in cost reduction, quality of care and patient safety, and prepare our members to succeed in a population health environment. We use an income statement method to address every area affecting the member's bottom line, finding opportunities in both revenue enhancement and expense management. Premier Performance Partners offers expertise and capabilities in the following areas: care coordination and physician engagement, clinical, financial and operational performance, facilities and capital asset management, organizational transformation, physician preference items (PPI), reform readiness assessment, clinical integration and population health operations and analytics, purchased services assessment, revenue cycle management and recovery audit contractor (RAC) readiness, service line improvement, strategic and business planning and supply chain transformation.

We provide a data-driven approach and expertise to deliver targeted results in reducing costs, increasing margin and improving quality. Using various specialists and advisors, we provide wrap-around services for our major SaaS informatics products and our GPO to enhance the member value from these programs. For example, our clinical performance partners provide U.S. hospitals with access to performance improvement and operational specialists. Using our informatics tools and applications, these clinical performance partners mine data for improvement opportunities and then lead or assist with improvement projects in such areas as resource and operational assessments, process improvement, performance improvement monitoring, strategic planning and knowledge transfer for organizational change. U.S. hospitals contract for clinical, financial and/or operational performance partner support for a given number of days per month, with contracts lasting from less than a year to five years in duration.

Performance Improvement Collaboratives:

QUEST® Collaborative. Through our QUEST® Collaborative (QUEST®), we work with our members to identify improvement opportunities and best practices and engage them to participate in performance improvement exercises using identified best practices, to collaborate to define performance goals and to use healthy competition to drive performance improvement. QUEST® builds on the past success of our partnership with CMS in the Premier Hospital Quality Incentive Demonstration, a value-based purchase program through which CMS awarded bonus payments to hospitals for high quality in several clinical areas and reported quality data on its website. The collaborative currently targets improvements in seven domains, including evidence-based care, cost and efficiency of care, patient and family engagement, safety, mortality and appropriate hospital use and community health. Historically, there were approximately 350 participating U.S. hospitals in the QUEST® 3.0 Collaborative, which sunset on December 31, 2016. In January 2017, we released the QUEST® 2020 collaborative, which was expanded to include additional focus areas, and which will continue to operate for the next three years. As of June 30, 2017, there were approximately 200 hospitals that have signed up for the QUEST® 2020 collaborative and that are working together to utilize our SaaS informatics products to develop highly standardized quality, safety and cost metrics. QUEST® seeks to develop next-generation quality, safety and cost metrics with a consistency and standardization we do not believe exists elsewhere today. We believe that our members who participate in QUEST® are better prepared to deal with healthcare reform requirements and, by improving in the seven domains referenced above, can earn Medicare incentives, avoid

Medicare penalties and better manage reimbursement cuts.

Bundled Payment Collaborative. Our Bundled Payment Collaborative assists our members in their participation in the CMS Bundled Payments for Care Improvement Initiative, an initiative by which organizations enter into payment arrangements that include financial and performance accountability for episodes of care. Our Bundled Payment Collaborative offers ongoing analysis of our members' Medicare Part A and Medicare Part B data, dashboards for managing bundled payment programs

and gainsharing, in addition to providing knowledge, expertise, and best practices from experts and members. As of June 30, 2017, we had approximately 50 health care systems and over 120 hospitals participating in our Bundled Payment Collaborative.

The Population Health Management Collaboratives. Our Population Health Management Collaborative, or PHM Collaborative (the successor to our PACT™-Partnership for Care Transformation collaborative), is focused on helping members develop and implement effective models of care and payment for connected groups of providers who take responsibility for improving the health status, efficiency and experience of care (quality and satisfaction) for a defined population (i.e., accountable care organizations) and how to align this care redesign with new value based payment arrangements. Our PHM Collaborative provides members with the opportunity to share value based care and payment developmental strategies, programs, and other best practices. The PHM Collaborative provides valuable assistance and access to over 30 PHM subject matter experts to members in developing the tools necessary to manage the health of a population and to exchange knowledge with each other and with industry and government experts. As of June 30, 2017, we had 70 health systems and Clinically Integrated Networks, comprised of over 500 hospitals in 42 states participating in our PHM Collaborative.

Hospital Improvement Innovation Network (formerly Partnership for Patients Collaborative). In September 2016, CMS awarded us a Partnership for Patients ("PfP") Hospital Improvement Innovation Network ("HIIN") contract to continue our prior Hospital Engagement Network efforts. The PfP initiative is a public-private collaborative working to improve the quality, safety and affordability of healthcare. Physicians, nurses, hospitals, employers, patients and their advocates, and the federal and state governments have joined together to form PfP to decrease preventable hospital-acquired conditions and readmissions. Our HIIN serves as a live learning lab for hospitals and utilizes HIIN partners to accelerate improvement efforts throughout multiple healthcare areas. As of June 30, 2017, we had approximately 475 hospitals participating in our HIIN collaborative.

Data Alliance Collaborative. A group of the nation's leading health systems have launched the Data Alliance Collaborative to ensure that healthcare providers have the technology and analytics in place to improve quality and lower costs. These forward-thinking providers are working together with Premier to disrupt the way healthcare information technology is developed. Data Alliance Collaborative members are using integrated data (e.g., clinical, claims, labor, supply chain, administrative, financial, patient experience, genomics, etc.) to develop new insights and answer the complex questions driven by the transformation to population-based care. They are innovating collaboratively to meet their current needs and are creating the conceptual and technical foundation that enables them to respond nimbly to an uncertain future. As of June 30, 2017, our Data Alliance Collaborative included 12 integrated data networks encompassing over 230 hospitals.

Insurance Services:

We provide insurance programs and services to assist U.S. hospital and healthcare system members with liability and benefits insurance services, along with risk management services. We design insurance programs and services for our members to improve their quality, patient safety and financial performance while lowering costs. We provide management services for American Excess Insurance Exchange, Risk Retention Group, a reciprocal risk retention group that provides excess hospital, professional, umbrella and general liability insurance to certain U.S. hospital and healthcare system members. We also negotiate the purchase of other insurance products from commercial insurance carriers on behalf of our members.

Pricing and Contracts

We generate revenue from our Supply Chain Services segment through fees received from suppliers based on the total dollar volume of supplies purchased by our members in connection with our GPO programs and through product sales in connection with our integrated pharmacy and direct sourcing activities. Our Performance Services segment has three main sources of revenue: (i) three to five-year subscription agreements to our SaaS informatics products, (ii) annual subscriptions to our performance improvement collaboratives and (iii) professional fees for our advisory services.

Supply Chain Services

Pursuant to the terms of GPO participation agreements entered into by the member owners (see Note 1 - Organization and Basis of Presentation to the accompanying audited consolidated financial statements for more information), each

of the member owners generally receives revenue share from Premier LP equal to 30% of all gross administrative fees collected by Premier LP based upon purchasing by such member owner's owned, leased, managed and affiliated facilities through our GPO supplier contracts. In addition, our two largest regional GPO member owners, which represented an aggregate of approximately 16% of our gross administrative fees revenue for the year ended June 30, 2017, each remit gross administrative fees collected by such member owner based upon purchasing by such member owner's owned, leased, managed and affiliated facilities through the member owner's own GPO supplier contracts, in accordance with such member owner's Premier GPO Agreement, and receive revenue share from Premier LP equal to 30% of such gross administrative fees remitted to us. Subject to certain termination rights, these GPO participation agreements are for an initial five-year term and expire on September 30, 2018, although our two largest regional

GPO member owners have entered into agreements with seven-year terms, which expire on September 30, 2020. GPO participation agreements automatically extend for successive five-year or seven-year periods (corresponding to the length of their initial terms) unless the member owner notifies Premier LP, prior to the fourth anniversary (September 30, 2017, in the case of five-year agreements), or sixth anniversary (September 30, 2019, in the case of seven-year agreements), of the then-current term, that such member owner desires to terminate the GPO participation agreement effective upon the expiration of the then-current term. In connection with these upcoming renewal notice deadlines, we have contacted member owners regarding their intentions with respect to renewals and we expect a significant number of members to renew.

Certain terms of the GPO participation agreements vary as a result of provisions in our pre-IPO arrangements with member owners that conflict with the terms of our standard GPO participation agreements and which by the express terms of the GPO participation agreement are incorporated by reference and deemed controlling and will continue to remain in effect. In limited circumstances, Premier LP and certain member owners entered into GPO participation agreements at the time of the IPO with certain terms that vary from the standard form. The agreements were approved by the member agreement review committee of our Board of Directors, based upon regulatory constraints, pending merger and acquisition activity or other exigent circumstances affecting those member owners. Certain non-owner members operate under contractual relationships that provide for a specific revenue share that differs from the 30% revenue share that we provide to our member owners under the current GPO participation agreements.

In our integrated pharmacy, we earn revenue from product sales and other services. Revenues are earned through traditional pharmacy dispensing services (i.e., retail and mail order), as well as “specialty pharmacy” services, including 340B drug pricing program dispensing services, administrative coordination, patient care management and data management reporting functions. Our integrated pharmacy contracts generally range from one to three years in length, and, except for exclusive networks, there are generally no guaranteed sales associated with a payer network contract.

In our direct sourcing activities, we earn revenue from product sales. Products are sold to our members through direct shipment and distributor and wholesale channels. Products are also sold to regional medical-surgical distributors and other non-healthcare industries (i.e., foodservice). We have contracts with our members that buy products through our direct shipment option. These contracts do not usually provide a guaranteed purchase or volume commitment requirement.

Performance Services

Performance Services revenue consists of SaaS informatics products subscriptions, certain perpetual and term licenses, performance improvement collaborative and other service subscriptions, professional fees for advisory and government services, and insurance services management fees and commissions from group-sponsored insurance programs.

SaaS informatics products subscriptions include the right to use our proprietary hosted technology on a SaaS basis, training and member support to deliver improvements in cost management, quality and safety, population health management and provider analytics. Pricing varies by subscription and size of the subscriber. Informatics subscriptions are generally three- to five-year agreements with automatic renewal clauses and annual price escalators that typically do not allow for early termination. These agreements do not allow for physical possession of the software. Subscription fees are typically billed on a monthly basis and revenue is recognized as a single deliverable on a straight-line basis over the remaining contractual period following implementation. Implementation involves the completion of data preparation services that are unique to each member's data set and, in certain cases, the installation of member site-specific software, in order to access and transfer member data into our hosted SaaS informatics products. Implementation is generally 60 to 300 days following contract execution before the SaaS informatics products can be fully utilized by the member.

Performance improvement collaborative and other service subscription revenue to support our offerings in cost management, quality and safety and population health management is recognized over the service period, which is generally one year.

Professional fees for advisory services are sold under contracts, the terms of which vary based on the nature of the engagement. Fees are billed as stipulated in the contract, and revenue is recognized on a proportional performance method as services are performed and deliverables are provided. In situations where the contracts have significant

contract performance guarantees or member acceptance provisions, revenue recognition occurs when the fees are fixed and determinable and all contingencies, including any refund rights, have been satisfied. Fees are based either on time and materials or the savings that are delivered.

Sales

We conduct sales through our embedded field force, our dedicated national sales team and our Premier Performance Partners advisors, collectively comprised of approximately 630 employees as of June 30, 2017.

Our field force works closely with our U.S. hospital members and other members to target new opportunities by developing strategic and operational plans to drive cost management and quality and safety improvement initiatives. As of June 30, 2017, our

field force was deployed to seven geographic regions and several strategic/affinity members across the United States. This field force works at our member sites to identify and recommend best practices for both supply chain and clinical integration cost savings opportunities. The regionally deployed field force is augmented by a national team of subject matter specialists who focus on key areas such as lab, surgery, cardiology, orthopedics, imaging, pharmacy, information technology and construction. Our field force assists our members in growing and supporting their alternate site membership.

Our sales team provides national sales coverage for establishing initial member relationships and works with our field force to increase sales to existing members. Our regional sales teams are aligned with the seven regions in our field force model.

Our Premier Performance Partners team identifies and targets advisory engagements and wrap-around services for our major SaaS informatics products and our GPO to enhance the member value from these programs.

Intellectual Property

We offer our members a range of products to which we have appropriate intellectual property rights, including online services, best practices content, databases, electronic tools, web-based applications, performance metrics, business methodologies, proprietary algorithms, software products and advisory services deliverables. We own and control a variety of trade secrets, confidential information, trademarks, trade names, copyrights, domain names and other intellectual property rights that, in the aggregate, are of material importance to our business.

We protect our intellectual property by relying on federal, state and common law rights, as well as contractual arrangements. We are licensed to use certain technology and other intellectual property rights owned and controlled by others, and, similarly, other companies are licensed to use certain technology and other intellectual property rights owned and controlled by us.

Research and Development

Our research and development, or R&D, expenditures primarily consist of our strategic investment in internally developed software to further our initiatives, and new product development in the areas of cost management, quality and safety and population health management. We have also made significant investments in our SaaS informatics product offerings. We expensed $3.1 million, $2.9 million and $2.9 million for R&D activities for fiscal years 2017, 2016 and 2015, respectively, and capitalized software development costs of $66.6 million, $61.0 million and $57.9 million for fiscal years 2017, 2016 and 2015, respectively. From time to time, we may experience fluctuations in our research and development expenditures, including capitalized software development costs, across reportable periods due to the timing of our software development life cycles, with new product features and functionality, new technologies and upgrades to our service offerings.

Competition

The markets for our products and services in both our Supply Chain Services segment and Performance Services segment are fragmented, intensely competitive and characterized by rapidly evolving technology and product standards, user needs and the frequent introduction of new products and services. We have experienced and expect to continue to experience intense competition from a number of companies.

The primary competitors to our Supply Chain Services segment are other large GPOs such as HealthTrust Purchasing Group (a subsidiary of HCA Holdings, Inc.), Intalere Inc., Managed Health Care Associates, Inc. and Vizient, Inc. In addition, we compete against certain healthcare provider-owned GPOs in this segment. Our integrated pharmacy competes with Accredo (owned by Express Scripts Holding Co.), BriovaRx, CVS Caremark Specialty Pharmacy (owned by CVS Health Corporation), Diplomat Pharmacy, Walgreens Specialty Pharmacy and many smaller local specialty pharmacies. Finally, our direct sourcing activities compete primarily with private label offerings/programs, product manufacturers and distributors, such as Cardinal Health, Inc., McKesson Corporation, Medline Industries, Inc. and Owens & Minor, Inc.

The competitors in our Performance Services segment range from smaller niche companies to large, well-financed and technologically-sophisticated entities. Our primary competitors in this segment include (i) information technology providers such as Allscripts Healthcare Solutions, Inc., Cerner Corporation, Epic Systems Corporation, Health Catalyst, LLC, IBM Corporation, Infor, Inc., McKesson Corporation and Oracle Corporation, and (ii) consulting and outsourcing firms such as The Advisory Board Company, Deloitte & Touche LLP, Evolent Health, Inc., Healthagen,

LLC (a subsidiary of Aetna, Inc.), Huron Consulting, Inc., Navigant Consulting, Inc., Optum, Inc. (a subsidiary of UnitedHealth Group, Inc.) and Vizient, Inc.

With respect to our products and services across both segments, we compete on the basis of several factors, including breadth, depth and quality of product and service offerings, ability to deliver clinical, financial and operational performance improvements through the use of products and services, quality and reliability of services, ease of use and convenience, brand recognition and the ability to integrate services with existing technology. With respect to our products and services across both of our business segments, we also compete on the basis of price.

Government Regulation

General

The healthcare industry is highly regulated by federal and state authorities and is subject to changing political, economic and regulatory influences. Factors such as changes in reimbursement policies for healthcare expenses, consolidation in the healthcare industry, regulation, litigation and general economic conditions affect the purchasing practices, operations and the financial health of healthcare organizations. In particular, changes in laws and regulations affecting the healthcare industry, such as increased regulation of the purchase and sale of medical products, or restrictions on permissible discounts and other financial arrangements, could require us to make unplanned modifications of our products and services, result in delays or cancellations of orders or reduce funds and demand for our products and services.

We are subject to numerous risks arising from governmental oversight and regulation. You should carefully review the following discussion and the risks discussed under “Item 1A. Risk Factors” for a more detailed discussion.

Affordable Care Act

The ACA is a sweeping measure designed to expand access to affordable health insurance, control healthcare spending and improve healthcare quality. The law includes provisions to tie Medicare provider reimbursement to healthcare quality and incentives, mandatory compliance programs, enhanced transparency disclosure requirements, increased funding and initiatives to address fraud and abuse and incentives to state Medicaid programs to promote community-based care as an alternative to institutional long-term care services. In addition, the law provides for the establishment of a national voluntary pilot program to bundle Medicare payments for hospital and post-acute services, which could lead to changes in the delivery of healthcare services. Likewise, many states have adopted or are considering changes in healthcare policies in part due to state budgetary shortfalls. Because implementation of many provisions of the ACA remains unsettled, we do not know what effect the ACA or state law proposals may have on our business. The 2016 election of President Trump and Republican majorities in both houses of Congress has resulted in additional efforts to repeal, replace, modify or delay implementation of the ACA, although these efforts are uncertain in light of the as-now discontinued efforts in the Senate to pass repeal and replace legislation. In January 2017, President Trump signed an executive order waiving various enforcement provisions under the ACA and it is not known how the administration will proceed if repeal and replace legislation is not passed by Congress. In June 2017, the House of Representatives passed legislation to repeal and replace the ACA, however in July 2017, the Senate rejected legislation to repeal and replace the ACA.

Civil and Criminal Fraud and Abuse Laws

We are subject to federal and state laws and regulations designed to protect patients, governmental healthcare programs and private health plans from fraudulent and abusive activities. These laws include anti-kickback restrictions and laws prohibiting the submission of false or fraudulent claims. These laws are complex and broadly-worded, and their application to our specific products, services and relationships may not be clear and may be applied to our business in ways that we do not anticipate. Federal and state regulatory and law enforcement authorities have over time increased enforcement activities with respect to Medicare and Medicaid fraud and abuse regulations and other reimbursement laws and rules. These laws and regulations include:

Anti-Kickback Laws. The federal Anti-Kickback Statute prohibits the knowing and willful offer, payment, solicitation or receipt of remuneration, directly or indirectly, in return for the referral of patients or arranging for the referral of patients, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered, in whole or in part, by a federal healthcare program such as Medicare or Medicaid. The definition of "remuneration" has been broadly interpreted to include anything of value such as gifts, discounts, rebates, waiver of payments or providing anything at less than its fair market value. Many states have adopted similar prohibitions against kickbacks and other practices that are intended to influence the purchase, lease or ordering of healthcare items and services regardless of whether the item or service is covered under a governmental health program or private health plan. Certain statutory and regulatory safe harbors exist that protect specified business arrangements from prosecution under the Anti-Kickback Statute if all elements of an applicable safe harbor are met, however these safe harbors are narrow and often difficult to comply with. Congress has appropriated an increasing amount of funds in recent years to support enforcement activities aimed at reducing healthcare fraud and abuse.

The U.S. Department of Health and Human Services, or HHS, created certain safe harbor regulations which, if fully complied with, assure parties to a particular arrangement covered by a safe harbor that they will not be prosecuted under the Anti-Kickback Statute. We attempt to structure our group purchasing services, pricing discount arrangements with suppliers, and revenue share arrangements with applicable members to meet the terms of the safe harbor for GPOs set forth at 42 C.F.R. § 1001.952(j) and the discount safe harbor set forth at 42 C.F.R. § 1001.952(h). Although full compliance with the provisions of a safe harbor ensures against prosecution under the Anti-Kickback Statute, failure of a transaction or arrangement to fit within a safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the Anti-Kickback Statute will be pursued. From time to time, HHS, through its Office of Inspector General, makes formal and informal inquiries, conducts investigations

and audits the business practices of GPOs, including our GPO, the result of which could be new rules, regulations or in some cases, a formal enforcement action.

To help ensure regulatory compliance with HHS rules and regulations, our members that report their costs to Medicare are required under the terms of the Premier Group Purchasing Policy to appropriately reflect all elements of value received in connection with our IPO on their cost reports. We are required to furnish applicable reports to such members setting forth the amount of such value, to assist their compliance with such cost reporting requirements. There can be no assurance that the HHS Office of Inspector General or the U.S. Department of Justice, or DOJ, will concur that these actions satisfy their applicable rules and regulations.

False Claims Act. Our business in general, and our integrated pharmacy in particular, is also subject to numerous federal and state laws that forbid the submission or "causing the submission" of false or fraudulent information or the failure to disclose information in connection with the submission and payment of claims for reimbursement to Medicare, Medicaid or other governmental healthcare programs or private health plans. In particular, the False Claims Act, or FCA, prohibits a person from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval by an officer, employee or agent of the United States. In addition, the FCA prohibits a person from knowingly making, using, or causing to be made or used a false record or statement material to such a claim. Violations of the FCA may result in treble damages, significant monetary penalties, and other collateral consequences including, potentially, exclusion from participation in federally funded healthcare programs. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute constitutes a false or fraudulent claim for purposes of the FCA.

Privacy and Security Laws. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, contains substantial restrictions and requirements with respect to the use and disclosure of certain individually identifiable health information, referred to as "protected health information." The HIPAA Privacy Rule prohibits a covered entity or a business associate (essentially, a third party engaged to assist a covered entity with enumerated operational and/or compliance functions) from using or disclosing protected health information unless the use or disclosure is validly authorized by the individual or is specifically required or permitted under the Privacy Rule and only if certain complex requirements are met. In addition to following these complex requirements, covered entities and business associates must also meet additional compliance obligations set forth in the Privacy Rule. In addition, the HIPAA Security Rule establishes administrative, organizational, physical and technical safeguards to protect the privacy, integrity and availability of electronic protected health information maintained or transmitted by covered entities and business associates. The HIPAA Security Rule requirements are intended to mandate that covered entities and business associates regularly re-assess the adequacy of their safeguards in light of changing and evolving security risks. Finally, the HIPAA Breach Notification Rule requires that covered entities and business associates, under certain circumstances, notify patients/beneficiaries, media outlets and HHS when there has been an improper use or disclosure of protected health information.

Our integrated pharmacy, our self-funded health benefit plan and our healthcare provider members (provided that these members engage in HIPAA-defined standard electronic transactions with health plans, which will be all or the vast majority) are directly regulated by HIPAA as "covered entities." From time to time, as part of our integrated pharmacy business, certain of our affiliates act as business associates of retail and other pharmacies in connection with co-branding initiatives. As such, we are subject to HIPAA and other risks discussed herein associated with being a business associate. Additionally, because most of our U.S. hospital members disclose protected health information to us so that we may use that information to provide certain data analytics, benchmarking, advisory or other operational and compliance services to these members, we are a "business associate" of those members. In these cases, in order to provide members with services that involve the use or disclosure of protected health information, HIPAA requires us to enter into "business associate agreements" with our covered entity members. Such agreements must, among other things, provide adequate written assurances:

(i) as to how we will use and disclose the protected health information within certain allowable parameters established by HIPAA,

(ii) that we will implement reasonable and appropriate administrative, organizational, physical and technical safeguards to protect such information from impermissible use or disclosure,

(iii) that we will enter into similar agreements with our agents and subcontractors that have access to the information,

(iv) that we will report breaches of unsecured protected health information, security incidents and other inappropriate uses or disclosures of the information, and

(v) that we will assist the covered entity with certain of its duties under HIPAA.

With the enactment of the Health Information Technology for Economic and Clinical Health, or HITECH Act, the privacy and security requirements of HIPAA were modified and expanded. The HITECH Act applies certain of the HIPAA privacy and security requirements directly to business associates of covered entities. Prior to this change, business associates had contractual obligations to covered entities but were not subject to direct enforcement by the federal government. In 2013, HHS released final rules implementing the HITECH Act changes to HIPAA. These amendments expanded the protection of protected health information

by, among other things, imposing additional requirements on business associates, further restricting the disclosure of protected health information in certain cases when the disclosure is part of a remunerated transaction, and modifying the HIPAA Breach Notification Rule, which has been in effect since September 2009, to create a rebuttable presumption that an improper use or disclosure of protected health information under certain circumstances requires notice to affected patients/beneficiaries, media outlets and HHS.

Transaction Requirements. HIPAA also mandates format, data content and provider identifier standards that must be used in certain electronic transactions, such as claims, payment advice and eligibility inquiries. Although our systems are fully capable of transmitting transactions that comply with these requirements, some payers and healthcare clearinghouses with which we conduct business may interpret HIPAA transaction requirements differently than we do or may require us to use legacy formats or include legacy identifiers as they make the transition to full compliance. In cases where payers or healthcare clearinghouses require conformity with their interpretations or require us to accommodate legacy transactions or identifiers as a condition of successful transactions, we attempt to comply with their requirements, but may be subject to enforcement actions as a result. In 2009, CMS published a final rule adopting updated standard code sets for diagnoses and procedures known as ICD-10 code sets and changing the formats to be used for electronic transactions subject to the ICD-10 code sets, known as Version 5010. All healthcare providers are required to comply with Version 5010 and use the ICD-10 code sets.

Other Federal and State Laws. In addition to our obligations under HIPAA there are other federal laws that impose specific privacy and security obligations, above and beyond HIPAA, for certain types of health information and impose additional sanctions and penalties. These rules are not preempted by HIPAA. Most states have enacted patient and/or beneficiary confidentiality laws that protect against the disclosure of confidential medical information, and many states have adopted or are considering adopting further legislation in this area, including privacy safeguards, security standards, data security breach notification requirements, and special rules for so-called "sensitive" health information, such as mental health, genetic testing results, or Human Immunodeficiency Virus, or HIV, status. These state laws, if more stringent than HIPAA requirements, are not preempted by the federal requirements, and we are required to comply with them as well.

We are unable to predict what changes to HIPAA or other federal or state laws or regulations might be made in the future or how those changes could affect our business or the associated costs of compliance.

Antitrust Laws

The Sherman Antitrust Act and related federal and state antitrust laws are complex laws that prohibit contracts in restraint of trade or other activities that are designed to or that have the effect of reducing competition in the market. The federal antitrust laws promote fair competition in business and are intended to create a level playing field so that both small and large companies are able to compete in the market. In their 1996 Statements of Antitrust Enforcement Policy in Health Care, or the Healthcare Statements, the DOJ and the Federal Trade Commission, or FTC, set forth guidelines specifically designed to help GPOs gauge whether a particular purchasing arrangement may raise antitrust concerns and established an antitrust safety zone for joint purchasing arrangements among healthcare providers. Under this antitrust safety zone, the DOJ and FTC will not challenge, except in extraordinary circumstances, joint purchasing arrangements among healthcare providers that meet two basic conditions: (i) the purchases made by the healthcare providers account for less than 35% of the total sales of the purchased product or service in the relevant market; and (ii) the cost of the products and services purchased jointly account for less than 20% of the total revenues from all products and services sold by each competing participant in the joint purchasing arrangement.

We have attempted to structure our contracts and pricing arrangements in accordance with the Healthcare Statements and believe that our GPO supplier contracts and pricing discount arrangements should not be found to violate the antitrust laws. No assurance can be given that enforcement authorities will agree with this assessment. In addition, private parties also may bring suit for alleged violations under the U.S. antitrust laws. From time to time, the group purchasing industry comes under review by Congress and other governmental bodies with respect to antitrust laws, the scope of which includes, among other things, the relationships between GPOs and their members, distributors, manufacturers and other suppliers, as well as the services performed and payments received in connection with GPO programs.

Congress, the DOJ, the FTC, the U.S. Senate or another state or federal entity could at any time open a new investigation of the group purchasing industry, or develop new rules, regulations or laws governing the industry, that could adversely impact our ability to negotiate pricing arrangements with suppliers, increase reporting and documentation requirements, or otherwise require us to modify our arrangements in a manner that adversely impacts our business. We may also face private or government lawsuits alleging violations arising from the concerns articulated by these governmental factors or alleging violations based solely on concerns of individual private parties.

Governmental Audits

Because we act as a GPO for healthcare providers that participate in governmental programs, our group purchasing services have in the past and may again in the future be subject to periodic surveys and audits by governmental entities or contractors for compliance with Medicare and Medicaid standards and requirements. We will continue to respond to these government reviews and audits but cannot predict what the outcome of any future audits may be or whether the results of any audits could significantly or negatively impact our business, our financial condition or results of operations.

Corporate Compliance Department

We execute and maintain a compliance and ethics program that is designed to assist the Company and its employees conduct operations and activities ethically with the highest level of integrity and in compliance with applicable laws and regulations and, if violations occur, to promote early detection and prompt resolution. These objectives are achieved through education, monitoring, disciplinary action and other remedial measures we believe to be appropriate. We provide all of our employees with education that has been developed to communicate our standards of conduct, compliance policies and procedures as well as policies for monitoring, reporting and responding to compliance issues. We also provide all of our employees with a third party toll-free number and Internet website address in order to report any compliance or privacy concerns. In addition, our Chief Ethics & Compliance Officer individually, and along with the Audit and Compliance Committee of the Board of Directors, helps oversee compliance and ethics matters across our business operations.

Employees

As of June 30, 2017, we employed approximately 2,400 persons, approximately 41% of whom are based in our headquarters in Charlotte, North Carolina. None of our employees are working under a collective bargaining arrangement.

Available Information

We file annual, quarterly and current reports, proxy statements and other information with the SEC. You may read and copy the documents that we file with the SEC at the SEC's Public Reference Room at 100 F Street, NE, Washington, DC 20549. You may obtain further information about the operation of the SEC's Public Reference Room by calling the SEC at 1-800-SEC-0330. You may also inspect these reports and other information without charge at a website maintained by the SEC. The address of this site is https://www.sec.gov. In addition, our website address is www.premierinc.com. We make available through our website the documents identified above, free of charge, promptly after we electronically file such material with, or furnish it to, the SEC.

We also provide information about our company through: Twitter (https://twitter.com/premierha), Facebook (https://www.facebook.com/premierhealthcarealliance), LinkedIn (https://www.linkedin.com/company/6766), YouTube (https://www.youtube.com/user/premieralliance), Instagram (https://instagram.com/premierha), Foursquare (https://foursquare.com/premierha) and Premier's blog (http://www.actionforbetterhealthcare.com).

Except as specifically indicated otherwise, the information available on our website, the SEC's website and the social media outlets identified above, is not and shall not be deemed a part of this Annual Report.

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Before making an investment in our Class A common stock or other securities we may have outstanding from time to time, you should carefully consider the following risks, as well as the other information contained in this annual report. Any of the risks described below could materially harm our business, financial condition, results of operations and prospects, and as a result, an investment in our Class A common stock or other securities we may have outstanding from time to time could decline, and you may lose part or all of the value of your investment. This section does not describe all risks that are or may become applicable to us, our industry, or our business, and it is intended only as a summary of certain material risk factors. Some statements in this annual report, including such statements in the following risk factors, constitute forward-looking statements. See the section entitled "Cautionary Note Regarding Forward-Looking Statements" for a discussion of such statements and their limitations. More detailed information concerning other risks or uncertainties we face, as well as the risk factors described below, is contained in other sections of this annual report.

Risks Related to Our Business

We face intense competition, which could limit our ability to maintain or expand market share within our industry and harm our business and operating results.

The market for products and services in each of our operating segments is fragmented, intensely competitive and characterized by rapidly evolving technology and product standards, dynamic user needs and the frequent introduction of new products and services. We face intense competition from a number of companies, including the companies listed under "Item 1 - Business - Competition." The primary competitors for our Supply Chain Services segment are other large GPOs, including in certain cases GPOs owned by healthcare providers. Our integrated pharmacy competes both with large national pharmacies and smaller local specialty pharmacies. Our direct sourcing activities compete primarily with private label offerings and programs, product manufacturers and distributors. The competitors in our Performance Services segment range from smaller niche companies to large, well-financed and technologically-sophisticated entities, and includes information technology providers and consulting and outsourcing firms.

With respect to our products and services in both segments, we compete on the basis of several factors, including breadth, depth and quality of our product and service offerings, ability to deliver clinical, financial and operational performance improvement through the use of products and services, quality and reliability of services, ease of use and convenience, brand recognition and the ability to integrate services with existing technology. Some of our competitors are more established, benefit from greater name recognition, have larger member bases and have substantially greater financial, technical and marketing resources. Other of our competitors have proprietary technology that differentiates their product and service offerings from our offerings. As a result of these competitive advantages, our competitors and potential competitors may be able to respond more quickly to market forces, undertake more extensive marketing campaigns for their brands, products and services and make more attractive offers to our members and potential new members.

We also compete on the basis of price in both of our segments. We may be subject to pricing pressures as a result of, among other things, competition within the industry, consolidation of healthcare industry participants, practices of managed care organizations, changes in laws and regulations applicable to our business operations, government action affecting reimbursement and financial stress experienced by our members. If our pricing experiences significant downward pressure, our business will be less profitable and our results of operations will be adversely affected. In this competitive environment, we cannot be certain that we will be able to retain our current members or expand our member base. If we do not retain current members or expand our member base, our business, financial condition and results of operations will be harmed. Moreover, we expect that competition will continue to increase as a result of consolidation in both the healthcare information technology and healthcare services industries. If one or more of our competitors or potential competitors were to merge or partner with another of our competitors, the change in the competitive landscape could also adversely affect our ability to compete effectively and could harm our business, financial condition and results of operations.

Consolidation in the healthcare industry could have a material adverse effect on our business, financial condition and results of operations.

Many healthcare industry participants are consolidating to create larger and more integrated healthcare delivery systems with greater market power. We expect regulatory and economic conditions to force additional consolidation in the healthcare industry in the future. As consolidation accelerates, the economies of scale of our members' organizations may grow. If a member experiences sizable growth following consolidation, it may determine that it no longer needs to rely on us and may reduce its demand for our products and services. Some of these large and growing healthcare systems may choose to contract directly with suppliers for certain supply categories, and some suppliers may seek to contract directly with the healthcare providers rather than with GPOs such as ours. In connection with any consolidation, our members may move their business to another GPO. In addition, as healthcare providers consolidate to create larger and more integrated healthcare delivery systems with greater market power, these providers

may try to use their market power to negotiate fee reductions for our products and services across both of our business segments. Finally, consolidation may also result in the acquisition or future development by our members of products and services that compete with our products and services. Any of these potential results of consolidation could have a material adverse effect on our business, financial condition and results of operations.

We may experience significant delays in recognizing revenue or increasing revenue if the sales cycle or implementation period with potential new members takes longer than anticipated.

A key element of our strategy is to market the various products and services in our Supply Chain Services and Performance Services segments directly to healthcare providers, such as health systems and acute care hospitals, and to increase the number of our products and services utilized by existing members. The evaluation and purchasing process is often lengthy and involves significant technical evaluation and commitment of personnel by these organizations. Further, the evaluation process depends on a number of factors, many of which we may not be able to control, including potential new members' internal approval processes, budgetary constraints for technology spending, member concerns about implementing new procurement methods and strategies and other timing effects. In addition, the contract or software implementation process for new products or services can take six months or more and, accordingly, delay our anticipated financial benefits from sales of such products or services. If we experience an extended or delayed implementation cycle in connection with the sale of additional products and services to existing or new members, it could have a material adverse effect on our business, financial condition and results of operations. In addition, changes in accounting standards that impact revenue recognition could adversely impact our ability to recognize revenue consistent with our historical practices and could have a material adverse effect on our business, financial condition and results of operations.

Member participation in our GPO programs may be terminated with limited or no notice and without significant termination payments. If our members reduce activity levels or terminate or elect not to renew their contracts, our revenue and results of operations may decrease materially.

We entered into new GPO participation agreements with all of our member owners existing immediately prior to the completion of our IPO. These GPO participation agreements are generally for an initial five-year term, although our two largest regional GPO member owners have entered into agreements with seven-year terms. These GPO participation agreements are generally terminable at any time by either party, upon one year's prior written notice, in addition to being terminable for cause. In addition, our GPO participation agreements automatically extend for successive five-year or seven-year periods (corresponding to the length of their initial terms) unless the member owner notifies Premier LP, prior to the fourth anniversary (September 30, 2017, in the case of five-year agreements), or sixth anniversary (September 30, 2019, in the case of seven-year agreements), of the then-current term, that such member owner desires to terminate the GPO participation agreement effective upon the expiration of the then-current term. Our success in retaining member participation in our GPO programs depends upon our reputation, strong relationships with such members and our ability to deliver consistent, reliable and high quality products and services; a failure in any of these areas may result in the loss of members. In addition, members may seek to reduce, cancel or elect not to renew their contracts due to factors that are beyond our control and are unrelated to our performance, including their business or financial condition, changes in their strategies or business plans or economic conditions in general. When contracts are reduced, canceled or not renewed for any reason, we lose the anticipated future revenue associated with such contracts and, consequently, our revenue and results of operations may decrease materially.

The markets for our non-GPO services and products may develop more slowly than we expect, which could adversely affect our revenue and our ability to maintain or increase our profitability.

Our success will depend on the willingness of existing and potential new members to increase their use of our SaaS informatics products. Many companies have invested substantial resources to integrate established enterprise software into their businesses and therefore may be reluctant or unwilling to switch to our products and services. Furthermore, some companies may have concerns regarding the risks associated with the security and reliability of the technology delivery model associated with these services. If companies do not perceive the benefits of our products and services, then the market for these products and services may not expand as much or develop as quickly as we expect, which would significantly adversely affect our business, financial condition and results of operations.

Our members are highly dependent on payments from third-party healthcare payers, including Medicare, Medicaid and other government-sponsored programs, and reductions or changes in third-party reimbursement could adversely affect these members and consequently our business.

Our members derive a substantial portion of their revenue from third-party private and governmental payers, including Medicare, Medicaid and other government sponsored programs. Our sales and profitability depend, in part, on the extent to which coverage of and reimbursement for our products and services our members purchase or otherwise obtain through us is available to our

members from governmental health programs, private health insurers, managed care plans and other third-party payers. These third-party payers are increasingly using their enhanced bargaining power to secure discounted reimbursement rates and may impose other requirements that adversely impact our members' ability to obtain adequate reimbursement for our products and services. If third-party payers do not approve our products and services for reimbursement or fail to reimburse for them adequately, our members may suffer adverse financial consequences which, in turn, may reduce the demand for and ability to purchase our products or services.

In addition, government actions could limit government spending generally for the Medicare and Medicaid programs, limit payments to healthcare providers and increase emphasis on competitive bidding programs that could have an adverse impact on our members and, in turn, on our business, financial condition and results of operations.

We rely on the administrative fees we receive from our GPO suppliers, and the failure to maintain contracts with these GPO suppliers could have a generally negative effect on our relationships with our members and could adversely affect our business, financial condition and results of operations.

Historically, we have derived a substantial amount of our revenue from the administrative fees that we receive from our GPO suppliers. We maintain contractual relationships with these suppliers which provide products and services to our members at reduced costs and which pay us administrative fees based on the dollars spent by our members for such products and services. Our contracts with these GPO suppliers generally may be terminated upon 90 days' notice. A termination of any relationship or agreement with a GPO supplier would result in the loss of administrative fees pursuant to our arrangement with that supplier, which could adversely affect our business, financial condition and results of operations. In addition, if we lose a relationship with a GPO supplier we may not be able to negotiate similar arrangements for our members with other suppliers on the same terms and conditions or at all, which could damage our reputation with our members and adversely impact our ability to maintain our member agreements or expand our membership base and could have a material adverse effect on our business, financial condition and results of operations.

In addition, CMS, which administers the Medicare and federal aspects of state Medicaid programs, has issued complex rules requiring pharmaceutical manufacturers to calculate and report drug pricing for multiple purposes, including the limiting of reimbursement for certain drugs. These rules generally exclude from the pricing calculation administrative fees paid by drug manufacturers to GPOs to the extent that such fees meet CMS's “bona fide service fee” definition. There can be no assurance that CMS will continue to allow exclusion of GPO administrative fees from the pricing calculation, which could negatively affect the willingness of pharmaceutical manufacturers to pay administrative fees to us.

If we are unable to maintain our relationships with third-party providers or maintain or enter into new strategic alliances, we may be unable to grow our current base business.

Our business strategy includes entering into and maintaining strategic alliances and affiliations with leading service providers and other GPOs. These companies may pursue relationships with our competitors, develop or acquire products and services that compete with our products and services, experience financial difficulties, be acquired by one of our competitors or other third party or exit the healthcare industry, any of which may adversely affect our relationship with them. In addition, in many cases, these companies may terminate their relationships with us for any reason with limited or no notice. If existing relationships with third-party providers or strategic alliances are adversely impacted or are terminated or we are unable to enter into relationships with leading healthcare service providers and other GPOs, we may be unable to maintain or increase our industry presence or effectively execute our business strategy.

If we are not able to timely offer new and innovative products and services, we may not remain competitive and our revenue and results of operations may suffer.

Our success depends on providing products and services within our Supply Chain Services and Performance Services segments that healthcare providers use to improve clinical, financial and operational performance. Information technology providers and other competitors are incorporating enhanced analytical tools and functionality and otherwise developing products and services that may become viewed as more efficient or appealing to our members. If we cannot adapt to rapidly evolving industry standards, technology and member needs, including changing regulations and provider reimbursement policies, we may be unable to anticipate changes in our current and potential new

members' requirements that could make our existing technology, products or service offerings obsolete. We must continue to invest significant resources in research and development in order to enhance our existing products and services, maintain or improve our product category rankings and introduce new high quality products and services that members and potential new members will want. If our enhanced existing or new products and services are not responsive to the needs of our members or potential new members, are not appropriately timed with market opportunity or are not effectively brought to market we may lose existing members and be unable to obtain new members and our results of operations may suffer.

We derive a significant portion of our revenues from our largest members, some of which are also GPOs that serve our members.

Our top five members, all of which are participants in our group purchasing programs, comprised approximately 16% of our consolidated net revenues for the year ended June 30, 2017. Our largest member, GNYHA and its member organizations, comprised approximately 7% of our consolidated net revenues for the same period. The sudden loss of any significant member or a number of smaller members that are participants in our group purchasing programs could materially and adversely affect our operating results. In addition, certain of our significant members are themselves GPOs with their own respective direct contracting relationships, including relationships with some of our other members. The sudden loss of any of these members may also result in increased competition for our Supply Chain Services segment and materially and adversely affect our operating results.

Our acquisition activities could result in operating difficulties, dilution, unrecoverable costs and other negative consequences, any of which may adversely impact our financial condition and results of operations.

Our business strategy includes growth through acquisitions of additional businesses and assets. Future acquisitions may not be completed on preferred terms, and acquired assets or businesses may not be successfully integrated into our operations or provide anticipated financial benefits. Any acquisitions we complete will involve risks commonly encountered in acquisitions of businesses. Such risks include, among other things:

- failing to integrate the operations and personnel of the acquired businesses in an efficient, timely manner;
- failure of a selling party to produce all material information during the pre-acquisition due diligence process, or to meet their obligations under post-acquisition agreements;
- potential liabilities of an acquired company, some of which may not become known until after the acquisition;
- an acquired company's lack of compliance with laws and governmental rules and regulations, and the related costs and expenses necessary to bring such company into compliance;
- an acquired company's general information technology controls may not be sufficient to prevent unauthorized access or transactions, cyber-attacks or other data security breaches;
- managing the potential disruption to our ongoing business;
- distracting management focus from our existing core businesses;
- encountering difficulties in identifying and acquiring products, technologies, or businesses that will help us execute our business strategy;
- entering new markets in which we have little to no experience;
- impairing relationships with employees, members, and strategic partners;
- failing to implement or remediate controls, procedures and policies appropriate for a public company at acquired companies lacking such financial, disclosure or other controls, procedures and policies, potentially resulting in a material weakness in our internal controls over financial reporting;
- the amortization of purchased intangible assets;
- incurring expenses associated with an impairment of all or a portion of goodwill and other intangible assets due to the failure of certain acquisitions to realize expected benefits; and
- diluting the share value and voting power of existing stockholders.

Anticipated benefits of our previous and future acquisitions may not materialize. Future acquisitions or dispositions of under-performing businesses could result in the incurrence of debt, contingent liabilities or amortization expenses or write-offs of goodwill and other intangible assets, any of which could harm our results of operations and financial condition. In addition, expenses associated with potential a