PharMerica CORP
Form 10-K
February 04, 2010
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2009

OR

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

Commission File Number: 001-33380

PHARMERICA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**87-0792558**
(State or other jurisdiction of	**(I.R.S. Employer**

incorporation or organization)	**Identification No.)**
1901 Campus Place	
Louisville, KY	**40299**
(Address of principal executive offices)	**(Zip Code)**

(502) 627-7000

(Registrant s telephone number, including area code)

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

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

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

N/A

(Title of class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ¨ No ¨

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

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

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

(Do not check if a smaller reporting company)

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

The aggregate market value of the voting and non-voting common equity of the registrant held by non-affiliates as of June 30, 2009 was $590,930,429.

Class of Common Stock	**Outstanding at January 29, 2010**
Common stock, $0.01 par value	30,621,615 Shares

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates certain information by reference from registrant s definitive proxy statement for the 2010 annual meeting of stockholders, which proxy statement will be filed no later than 120 days after the close of the registrant s fiscal year ended December 31, 2009.

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PART I

Item 1. Business

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

Under the terms of the Pharmacy Transaction, on the Closing Date, each of KPS and PharMerica LTC borrowed $125.0 million as mutually agreed upon by Kindred and AmerisourceBergen and used such proceeds to fund a one-time, tax-free cash distribution in that amount to their respective parent companies. Following the cash distributions, Kindred spun off to its stockholders all of the outstanding stock of KPS and AmerisourceBergen spun off to its stockholders all of the outstanding stock of PharMerica LTC. Immediately thereafter, separate wholly owned subsidiaries of the Corporation were merged with and into KPS and PharMerica LTC with KPS and PharMerica LTC as the surviving entities of the mergers, and, as a result, KPS and PharMerica LTC became wholly owned subsidiaries of the Corporation. Immediately following such spin-offs and mergers, the stockholders of Kindred and AmerisourceBergen each owned 50% of the outstanding common stock of the Corporation. The shares of the Corporation s common stock held by Kindred and AmerisourceBergen prior to the Pharmacy Transaction were cancelled, and neither retained any ownership of the outstanding shares of common stock of the Corporation.

Prior to the closing of the Pharmacy Transaction, the Corporation had no assets or liabilities and conducted no business activity. Prior to the closing of the Pharmacy Transaction, the business was operated as separate businesses within two different public companies, Kindred and AmerisourceBergen.

Reporting Entity

For accounting purposes, the Pharmacy Transaction was treated as an acquisition by KPS of PharMerica LTC with KPS being considered the accounting acquirer. As a result, the accompanying consolidated financial statements include certain accounts and results of operations representing the institutional pharmacy business of Kindred on a carve-out basis. Because KPS was determined to be the acquirer for accounting purposes, the historical financial statements of KPS became the historical financial statements of the Corporation. Accordingly, the financial statements of the Corporation prior to the Pharmacy Transaction reflect the financial position, results of operations and cash flows of KPS, which during the historical periods presented in the accompanying consolidated financial statements, was a wholly owned subsidiary of Kindred. Following the Pharmacy Transaction, the financial statements reflect the financial position, results of operation and cash flows of the Corporation. The results of operations of PharMerica LTC are included in the results of operations of the Corporation beginning August 1, 2007. Therefore, the consolidated financial statements included in this report on Form 10-K as of December 31, 2008 and 2009 and for the years ended December 31, 2007, 2008 and 2009 reflect the financial position, results of operations and cash flows of the Corporation, which during the first seven months of 2007, KPS was a wholly owned subsidiary of Kindred.

The Corporation operates two business segments: institutional pharmacies and hospital pharmacy management. Institutional pharmacies provide pharmacy services to nursing centers and other healthcare providers and the hospital pharmacy management business provides management services primarily to Kindred s hospitals.

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Reclassifications

For the year ended December 31, 2007, the Corporation has reclassified $27.9 million from Integration, merger and acquisition related costs and other charges to provision for doubtful accounts, a component of Selling, general and administrative expenses in the consolidated statement of operations. The $27.9 million increase in the allowance for doubtful accounts is related to the acquired receivables of PharMerica LTC as of July 31, 2007, and is unrelated to the accounts receivable and revenue of KPS. These reclassification have no impact on the Corporation s total assets, liabilities, stockholders equity, net income (loss) or cash flows for the year ended December 31, 2007.

Institutional Pharmacy Business

The Corporation is the second largest institutional pharmacy services company in the United States based on revenues. We service healthcare facilities and provide management pharmacy services to hospitals. The Corporation operates 98 institutional pharmacies in 41 states. The Corporation s customers are typically institutional healthcare providers, such as skilled nursing facilities, assisted living facilities, hospitals, and other long-term alternative care settings. The Corporation is generally the primary source of supply of pharmaceuticals to its customers. The Corporation also provides pharmacy management services to 86 hospitals in the United States.

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

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

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

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Consultant Pharmacist Services

Federal and state regulations mandate that long-term care facilities, in addition to providing a source of pharmaceuticals, retain consultant pharmacist services to monitor and report on prescription drug therapy in order to maintain and improve the quality of resident care. The Omnibus Budget Reconciliation Act of 1987 (OBRA of 1987) implemented in 1990 sought to further upgrade and standardize care by setting forth more stringent standards relating to planning, monitoring, and reporting on the progress of prescription drug therapy, as well as overall drug usage. In addition, the Centers for Medicare & Medicaid Services (CMS) issued revised guidelines to surveyors of long-term care facilities which, effective December 18, 2006, expanded the scope and detail in which surveyors are assessing pharmacy services at facilities, including consultant pharmacy services. In addition, on September 30, 2008, the United States Department of Health and Human Services (HHS) Office of Inspector General published *OIG Supplemental Compliance Program Guidance for Nursing Facilities.* With quality of care the first risk area identified, the supplemental guidance is part of a series of recent government efforts focused on improving quality of care at skilled nursing and long-term care facilities. The guidance contains new compliance recommendations and an expanded discussion of risk areas. The guidance stressed that facilities must provide pharmaceutical services to meet the needs of each resident and should be mindful of potential quality of care problems when implementing policies and procedures on proper medication management. It further stated that facilities can reduce risk by educating staff on medication management and improper pharmacy kickbacks for consultant pharmacists and that facilities should review the total compensation paid to consultant pharmacists to ensure it is not structured in a way that reflects the volume or value of particular drugs prescribed or administered to residents.

We provide consultant pharmacist services that help our customers comply with the federal and state regulations applicable to nursing homes. The services offered by our consultant pharmacists include:

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

These services, while costly, may be replicated by local providers.

Ancillary Services

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

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

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Hospital Pharmacy Management Services

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

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

Our Business Focus

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

Driving Organic Sales. We aim to grow our business through expansion in our existing markets and by servicing new customers. We intend to grow organically. We believe our industry has underlying market growth potential attributable to both an increase in drug utilization as well as the general aging population of the United States. We believe the Pharmacy Transaction improved our market competitiveness by giving us more operating scale and increased organizational breadth and depth. We seek to increase our market share, in part, by capturing business currently conducted by our competitors and capitalizing on our improved market position.

Acquiring Competitors. We also intend to expand our market share through selected geographic expansion in markets not currently served by us and through strategic acquisitions in existing and underserved markets. The Corporation currently operates in 41 states. We believe there are growth opportunities in several other markets. There are numerous businesses in our market, mostly small or regional companies that lack the scale that we believe will be necessary to ultimately compete in a market that is national in scope. We intend to actively seek opportunities to acquire these companies.

Sales and Marketing

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

Customers

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

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

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At December 31, 2009, we had contracts to provide pharmacy services to 317,885 licensed beds for patients in healthcare facilities in 41 states. We also have significant customer concentrations with facilities operated by Kindred. For the year ended December 31, 2009, Kindred institutional pharmacy contracts represented approximately 10.0% of the Corporation s total revenues.

Hospital Pharmacy Management Services. At December 31, 2009, the Corporation had provided hospital management services to Kindred and other customers at 86 locations. For the year ended December 31, 2009, revenues under the Kindred hospital pharmacy management service contracts represented approximately 3.0% of the Corporation s total revenues.

Suppliers/Inventory

At the consummation of the Pharmacy Transaction, the Corporation entered into a Prime Vendor Agreement (the Prime Vendor Agreement), with AmerisourceBergen Drug Corporation (ABDC), a wholly owned subsidiary of AmerisourceBergen, the Corporation s former 50% stockholder. Pursuant to this agreement, the Corporation agreed to purchase at least 95% of the Corporation s prescription pharmaceutical drugs from ABDC and to participate in ABDC s generic formulary purchase program for a period of five years, ending on July 31, 2012. In addition, ABDC supports the distribution of pharmaceuticals that the Corporation contracts directly with manufacturers and provides inventory management support. Also, under the provisions of the agreement, the Corporation may not undertake any merger, change of ownership, change in control or other transaction without the consent of ABDC unless certain conditions are met, including the surviving entity is believed in good faith to be obligated to assume all obligations under the agreement.

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

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

Supplier and Manufacturer Rebates

We currently receive rebates from certain manufacturers and distributors of pharmaceutical products for achieving targets of market share or purchase volumes. Rebates are designed to prefer, protect, or maintain a manufacturer s products that are dispensed by the pharmacy under its formulary. Rebates for brand name products are generally based upon achieving a defined market share tier within a therapeutic class. Rebates for generic products are more likely to be based on achieving volume requirements. Rebates included in our statements of operations were $31.7 million, $50.6 million, and $49.5 million for the years ended December 31, 2007, 2008, and 2009, respectively.

For more information regarding rebates, see Overview of Reimbursement.

Brand versus Generic

The pharmaceutical industry has been experiencing a higher level of brand to generic drug conversions. We expect an increase in the demand for generic drugs as the result of a large number of patent expirations.

The following table summarizes the historical generic drug dispensing rate:

	2007	2008	2009
Generic despensing rate:	67.4%	70.7%	74.2%

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The following table summarizes the material anticipated brand to generic conversions from 2010 to 2015 that were in the top 50 drug spend for the Corporation during the year ended December 31, 2009:

2010	2011	2012	2013	2014	2015
Mirapex (1Q)	Actos (1Q)	Geodon (1Q)	Xopenex (1Q)	Exelon (1Q)	Abilify (2Q)
Flomax (1Q)	Levaquin (2Q)	Seroquel (1Q)	Humalog (2Q)	Nexium (2Q)	Zyvox (2Q)
Effexor XR (3Q)	Xalatan (3Q)	Plavix (1Q)	Cymbalta (4Q)	Celebrex (2Q)	Namenda (2Q)
Aricept (4Q)	Advair (3Q)	Singulair (1Q)		Copaxone (4Q)	
	Zyprexa (4Q)	Detrol (1Q)			
	Lipitor (4Q)	Lovenox (1Q)			
		Lexapro (3Q)			
		Diovan (3Q)			
		Diovan HCT (4Q)			

(Number in parentheses equals the quarter of conversion)

Historically, when a branded drug shifts to a generic, initial pricing of the generic drug in the market will vary depending on the number of manufacturers launching their generic version of the drug. It is believed that a shift from brand to generic will decrease our revenue but at the same time may improve our gross margin from sales of these classes of drugs during the initial time period a brand drug has a generic alternative. The amount of improvement in gross margin is also dependent on the particular brand not being granted an exclusivity period and actual contracted terms with customers. In addition, once a generic has been introduced and multiple manufacturers begin producing alternatives, the Corporation is likely to see margin compression as reimbursement declines. Due to the nature of the brand to generic conversion, management cannot estimate the financial impact of the brand to generic conversions from 2010 to 2015 on its results of operations.

Information Technology

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

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

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

Except for certain services that will be provided at cost, KHOI will provide such services to the Corporation at its cost plus 10%, which will be the actual costs and expenses incurred in providing these services, including certain overhead costs and per hour costs of the KHOI employees providing the services. The initial term of the agreement is five years. The agreement will automatically renew for successive one-year periods after the expiration of the initial five year term, absent 120 days prior written notice of termination as provided for in the agreement. The IT Services Agreement may be terminated by either party for cause and, in certain circumstances, by the Corporation in the event that KHOI undergoes a change of control to one of the Corporation s competitors. Following termination of the IT Services Agreement, KHOI must provide termination and expiration assistance for up to 180 days. The Corporation has incurred costs of $7.3 million, $17.3 million and $11.5 million for the years ended December 31, 2007, 2008 and 2009, respectively, under the IT Services Agreement.

Sources of Pharmacy Revenues

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

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

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

	2007		2008		2009	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare Part D	$ 550.2	45.2%	$ 885.8	45.5%	$ 852.6	46.3%
Institutional healthcare providers	369.3	30.3	577.2	29.7	545.6	29.6
Medicaid	108.8	8.9	181.1	9.3	165.8	9.0
Private and other	77.7	6.4	133.2	6.8	122.4	6.6
Insured	46.8	3.8	101.4	5.2	91.5	5.0
Medicare	10.2	0.9	10.1	0.5	6.8	0.4
Hospital management fees	54.8	4.5	58.5	3.0	56.5	3.1
Total	$ 1,217.8	100.0%	$ 1,947.3	100.0%	$ 1,841.2	100.0%

Competition

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

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

Patents, Trademarks and Licenses

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

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

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

Seasonality

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

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Working Capital

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

Corporate Integrity Agreement

On March 29, 2005, PharMerica LTC and the Office of Inspector General within the Department of Health and Human Services (OIG) entered into the Corporate Integrity Agreement (CIA) to promote compliance with the requirements of the federal healthcare programs. Under the CIA, PharMerica LTC agreed to continue its comprehensive compliance program, which includes a corporate compliance officer, a corporate compliance committee, a Code of Ethics and Business Conduct, written policies and procedures, educational and training initiatives, review and disciplinary procedures, a confidential disclosure program, an ineligible persons screening program, and internal audit and review procedures, all designed to promote compliance with applicable laws, including federal healthcare program requirements and the promotion of ethical business practices. PharMerica LTC is also subject to extensive reporting requirements under the CIA, including annual reports describing PharMerica LTC s compliance activities, notices of any government investigations or legal proceedings, overpayments received from federal healthcare programs and changes in pharmacy locations and new business units. The term of the CIA is five years and it ends on March 29, 2010. PharMerica LTC is required to comply fully and timely with all of the CIA requirements. Failure to do so may lead to the imposition of stipulated penalties, including substantial monetary penalties and exclusion from participation in federal healthcare programs, including Medicare and Medicaid. Any such penalties could have a material adverse effect on our financial position, results of operations, and liquidity.

The CIA continues to apply to PharMerica LTC through its original term. Pursuant to an agreement reached with the OIG regarding the Pharmacy Transaction s impact on the CIA, the CIA s requirements do not apply to KPS or any of the KPS employees or contractors. However, among other obligations, the Corporation s employees and contractors that are involved with PharMerica LTC s operations will be subject to training requirements in accordance with the CIA s existing terms. In addition, pursuant to the agreement reached with the OIG, oversight of, and day-to-day responsibility for, the CIA is undertaken by the Corporation s compliance officer and the Corporation s compliance committee (an ad hoc committee comprised of members of the Corporation s senior management).

Employees

As of December 31, 2009, we have approximately 5,800 employees which includes approximately 1,100 part-time employees. None of our employees are covered by collective bargaining agreements. We employ approximately 1,600 licensed pharmacists. We believe that our relationships with our employees are good.

Government Regulation

General

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

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Licensure, Certification and Regulation

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

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

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

On September 20, 2006, CMS issued revised guidance to surveyors of long term care facilities regarding the survey protocol for review of pharmacy services provided in long-term care facilities participating in the Medicare and Medicaid programs. The new guidelines, which became effective December 18, 2006, expanded the areas and detail in which surveyors are to assess pharmacy services at the facility, including ordering, acquiring, receiving, storing, labeling, dispensing and disposing of all medications at the facility; the provision of medication-related information to health care professionals and residents; the process of identifying and addressing medication-related issues through medication regimen reviews and collaboration between the licensed consultant pharmacist, the facility and other healthcare professionals; and the provision, monitoring and use of medication-related devices. The guidelines also emphasize the important role of consultative services of pharmacists in promoting safe and effective medication use through the coordination of all aspects of pharmacy services provided to all residents within a facility. In addition, on September 30, 2008, the OIG published *OIG Supplemental Compliance Program Guidance for Nursing Facilities*. With quality of care the first risk area identified, the supplemental guidance is part of a series of recent government efforts focused on improving quality of care at skilled nursing and long-term care facilities. The guidance contains new compliance recommendations and an expanded discussion of risk areas. The guidance stressed that facilities must provide pharmaceutical services to meet the needs of each resident and should be mindful of potential quality of care problems when implementing policies and procedures on proper medication management. It further stated that facilities can reduce risk by educating staff on medication management and improper pharmacy kickbacks for consultant pharmacists and that facilities should review the total compensation paid to consultant pharmacists to ensure it is not structured in a way that reflects the volume or value of particular drugs prescribed or administered to residents.

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Laws Affecting Referrals and Business Practices

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

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

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

These laws impact the relationships that we may have with potential referral sources. We have a variety of relationships with potential referral sources, including hospitals and skilled nursing facilities with which we have contracted to provide pharmacy services. With respect to the anti-kickback statute, the OIG has enacted safe harbor regulations that outline practices that are deemed protected from prosecution. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, none of which is material to us, may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. While we believe our practices comply with the anti-kickback statute, we cannot assure you that our practices that are outside of a safe harbor will not be found to violate the anti-kickback statute.

As one means of providing guidance to healthcare providers, the OIG issues Special Fraud Alerts. These alerts do not have the force of law, but identify features of arrangements or transactions that may indicate that the arrangements or transactions violate the anti-kickback statute or other federal health care laws. The OIG has identified several arrangements, which, if accompanied by inappropriate intent, constitute suspect practices, including: (a) the use of free or significantly discounted office space or equipment in facilities, (b) provision of free or significantly discounted billing, nursing or other staff services, (c) free training in areas such as management techniques and laboratory techniques, (d) purchasing goods or services from potential referral sources at prices in excess of their fair market value, and (e) rental of space from potential referral sources at other than fair market value terms. The OIG has encouraged persons having information about entities that offer the above types of incentives to report such information to the OIG.

The OIG also issues Special Advisory Bulletins as a means of providing guidance to healthcare providers. These bulletins, along with the Special Fraud Alerts, have focused on certain arrangements that could be subject to heightened scrutiny by government enforcement authorities, including contractual joint venture arrangements and other joint venture arrangements between those in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG from time to time issues compliance program guidance for certain types of healthcare providers. These guidance documents contain voluntary actions for providers to consider to promote compliance with Medicare, Medicaid and other federal healthcare programs. Although the OIG has not issued compliance guidance for long-term care pharmacies, the OIG has issued compliance guidance for hospitals, nursing facilities and suppliers of durable medical equipment, which may be instructive. These guidance documents advise entities to adopt policies and procedures to address the risks arising from, among other things: (a) arrangements with vendors that result in the facility receiving non-covered items at below market prices or at no charge, provided the facility orders Medicare-reimbursed products, (b) soliciting or receiving items of value in exchange for providing the supplier access to patients medical records and other information needed to bill Medicare, (c) joint ventures with entities supplying goods or services, and (d) discounts and other financial incentives given to potential referral sources.

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Further, the OIG frequently issues Advisory Opinions to provide specific guidance on the applicable health care fraud laws and regulations. Interested parties are able to submit detailed information to the OIG describing a particular arrangement and the OIG will explain whether or not it implicates these laws and whether or not the OIG will elect to enforce in the described situation. Although these opinions are only binding for the party disclosing, they provide helpful guidance on a variety of potential arrangements with physicians.

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

Other provisions in the Social Security Act and in other federal and state laws authorize the imposition of penalties, including criminal and civil fines and exclusions from participation in Medicare, Medicaid and other federal healthcare programs for false claims, improper billing and other offenses. These laws include the federal False Claims Act, under which private parties have the right to bring qui tam whistleblower lawsuits against companies that submit false claims for payments to the government. Recent changes to the False Claims Act, expanding liability to certain additional parties and circumstances, may make these qui tam law lawsuits more prevalent. Some states have adopted similar state whistleblower and false claims laws.

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

In the ordinary course of business, we are subject regularly to inquiries, investigations and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations for regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments and fines. To date, we have not experienced any demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments or fines that are material to us. However, such sanctions could have a material adverse effect on our financial position, results of operation and liquidity.

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

State Laws Affecting Access to Services

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

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HIPAA

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

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

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

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

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

Stimulus Package

The American Recovery and Responsibility Act, commonly known as the Stimulus Package, is a $787.0 billion federal bill intended to stimulate the economy through both tax cuts and increased government spending. Within this package there are a variety of healthcare-related provisions including (i) the $87.0 billion temporary increase in Medicaid Federal Medical Assistance Percentage (FMAP), and (ii) the $21.0 billion of funding to encourage adoption of certain health information technology (HIT).

Under Medicaid FMAP, the federal government matches certain state expenditures for Medicaid social service programs. As such, the $87.0 billion increase in FMAP goes directly from the federal government to eligible states. Eligible states will receive a minimum 6.2% FMAP increase retroactive to October 1, 2008 and going forward to December 31, 2010, with additional funds going to states with higher unemployment rates. To ensure eligibility for the FMAP increase, states must maintain or reinstate previously required Medicaid eligibility standards, comply with prompt pay requirements and meet certain other specific criteria. Although the funds are through the FMAP program, states receive the money as general funds and, aside from a prohibition against placing the money in a rainy day fund, may expend the funds at the states discretion. HHS continues to release determinations of enhanced payments on a rolling basis, effective for the quarter-year periods.

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The Stimulus Package also provides $21.0 billion designated for investment in HIT infrastructure and Medicare and Medicaid incentives to encourage doctors, hospitals, and other providers to adopt HIT. Of this funding, $2.0 billion is set aside for adoption activities while $19.0 billion will go to providers engaged in the meaningful use of electronic health records (EHR). Meaningful users are providers who use certified EHR technology, exchange EHR information to improve quality and coordination of care, and use EHR to submit quality measures. For physicians, the structure largely mirrors the e-prescribing framework set out in the Medicare Improvements for Patients and Providers Act (MIPPA) by incentivizing adoption of HIT through granting up to $44,000 per physician until 2014, and thereafter penalizing physicians who have not yet adopted. Similarly, hospitals are eligible for bonus payments if determined to be meaningful users of EHR. The impact of these provisions, according to the Congressional Budget Office, will be that approximately 90% of doctors and 70% of hospitals adopt EHR technology over the next 10 years. The impact of the Stimulus Package is unclear at this time.

Proposed Federal Budget and Health Care Reform

The proposed federal budget for fiscal year 2010 builds on the health provisions of the Stimulus Package while simultaneously introducing new healthcare-related programs generally aimed at improving quality, efficiency, and accountability, and at encouraging shared responsibility for health care. The proposed budget does not include many program specifics and will not necessarily parallel the final version as altered and approved by Congress. The most significant aspect of the proposed budget is a new $630.0 billion reserve fund to help finance future healthcare reform. This is proposed to be funded by both tax changes and Medicare and Medicaid reform. The budget specifies increasing Medicaid rebates and broadening utilization of generics as some of the many parts of the Health Reform Reserve Fund. The exact nature and structure of such reform is being debated by Congress and the Obama administration and cannot be predicted with any certainty. In conjunction, Congress and the Obama administration are debating significant restructuring of the health care system as a whole, the impact of which is unclear at this time.

Beyond healthcare reform, the budget expands funding for a variety of programs including comparative effectiveness and cancer research. In addition, the proposed budget builds on and implements a variety of provisions of the Stimulus Package. At this time, however, all these provisions are solely the administration s recommendation. The House and Senate are currently working on separate versions of the budget. Without a final version of the appropriations bills, we are unable to analyze the potential impact of these fiscal changes on our business.

Federal Trade Commission Red Flag Rules

The recently issued Identity Theft Red Flag and Address Discrepancy Rules, referred to as the Red Flag Rules, which the FTC will begin to enforce on June 1, 2010, require creditors that maintain certain kinds of covered accounts to develop and implement a written program to detect and respond to identity theft. Because the Corporation does not require full payment at the time of service of a patient, it will be considered a creditor for purposes of the Red Flag Rules. Therefore, the Corporation will be required to implement a program to detect and respond to identity theft. Failure to implement a program by the deadline can result in substantial monetary penalties. The deadline for compliance with these rules, as well as the scope of their application, has been subject to various regulatory, legislative, and judicial changes. As such, we cannot fully analyze the potential impact of these Red Flag Rules on our business.

Overview of Reimbursement

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

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

Medicare

The Medicare program consists of four parts: (1) Medicare Part A, which covers, among other things, in-patient hospital, skilled nursing facilities, home healthcare, and certain other types of healthcare services; (2) Medicare Part B, which covers physicians services, outpatient services, and certain items and services provided by medical suppliers such as intravenous therapy; (3) a managed care option for beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, known as Medicare Part C or Medicare Advantage; and (4) Medicare Part D, which provides coverage for prescription drugs that are not otherwise covered under Medicare Part A or Part B for those beneficiaries that enroll.

Part A

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

Federal legislation continues to focus on reducing Medicare and Medicaid program expenditures. The Deficit Reduction Act of 2005, or DRA, is intended to reduce net Medicare and Medicaid spending by approximately $11.0 billion over five years. Among other things, the DRA reduces certain bad debt payments to Medicare skilled nursing facilities by 30 percent for those individuals who are not dually eligible for Medicare and Medicaid. It also strengthens asset transfer restrictions for people seeking to qualify for Medicaid long-term care coverage. This provision is expected to reduce payments to skilled nursing facilities by approximately $100 million over five years (fiscal years 2006-2010). In addition, CMS has proposed or finalized multiple rules decreasing both skilled nursing facilities PPS payments and long-term care hospital PPS payments. Such decreases may directly impact the Corporation s customers and their Medicare reimbursement. Given the changing nature of these rules, we are unable at this time to fully evaluate the impact on our business. Any evaluation of budgeting, cost-cutting, and financing of health care must also consider the new federal administration and the impact its proposed health care policies could have on any future cost considerations.

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Part B

The MMA also changed the Medicare payment methodology and conditions for coverage of certain items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) under Medicare Part B. The Corporation provides some of these products to its nursing home customers. The changes include, among other things, a new competitive bidding program. Beginning on January 1, 2011, only suppliers that are winning bidders will be eligible to provide services, at prices established as a result of the competitive bids, to Medicare beneficiaries in the selected areas. Enteral nutrients, equipment and supplies, and oxygen equipment and supplies are among the 10 categories of DMEPOS included in the first round of the competitive bidding process. The Corporation did not participate in the bidding process, however, it will still be able to sell products not in the categories described above that are otherwise reimbursed under Medicare Part B. Integrity Medical Supplies, LLC, a recently acquired company, did participate in the bidding process and is awaiting the results of the bids. CMS intends to announce the payment amounts and to begin the contracting process with the bidders in June 2010 and to publicly announce the contracted suppliers in September 2010. The Corporation will continue to evaluate whether it will participate in Round 2 of the bidding, which is not yet scheduled.

Part D

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

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

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

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

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

In addition, we receive rebates from pharmaceutical manufacturers for undertaking certain activities that the manufacturers believe may increase the likelihood that we will dispense their products. CMS continues to question whether institutional pharmacies should be permitted to receive these access/performance rebates from manufacturers with respect to prescriptions covered under Medicare Part D, but has not prohibited the receipt of such rebates. CMS defines these as rebates a manufacturer provides to long-term care pharmacies that are designed to prefer, protect, or maintain that manufacturer s product selection by the long-term care pharmacy or to increase the volume of that manufacturer s products that are dispensed by the pharmacy under its formulary. CMS, in 2007, required PDPs to have policies and systems in place as part of their drug utilization management programs to protect beneficiaries and reduce costs when long-term care pharmacies receive incentives to move market share through access/performance rebates. The elimination or reduction of manufacturer rebates, if not offset by other reimbursement, could have an adverse effect on our business.

Other

On July 15, 2008, MIPPA of 2008 was enacted. MIPPA cancels a reduction in Medicare s payment rates for physicians services that went into effect on July 1, 2008 and extends other expiring provisions governing the Medicare program. It also increases payment rates for physician s services for 2009, expands eligibility for low-income benefits, and reduces payments to Medicare Advantage Plans. The various provisions that could impact our operations are as follows:

Incentives for Electronic Prescribing Providers who electronically prescribe (e-Rx) are eligible to receive bonus payments based on a percentage of Medicare allowable charges through 2013. Beginning in 2014, penalty payments will become effective for providers who fail to use e-Rx.

Low-Income Subsidy The legislation eliminates the Part D late-enrollment penalty for low income beneficiaries and specifies that certain income and assets be disregarded in determining eligibility for the low-income subsidy program in Part D. MIPPA also provides additional funds to federal and state entities to increase outreach efforts to encourage eligible individuals to enroll in those programs.

Prompt Pay Beginning 2010, long-term care (LTC) pharmacies will be required to submit Part D claims to PDP s no less than 30 days but no more than 90 days from the date the drugs are dispensed for reimbursement.

Formularies This provision legislatively expands the list of covered Part D drugs. This provision also offers CMS the authority to designate certain classes of drugs as having a protected status. CMS announced that it will maintain its current six protected classes policy antidepressants, antipsychotics, antiretrovirals, immunosuppresants, anticonvulsants, and antineoplastics.

These various provisions of MIPPA are currently being implemented through CMS rules and regulations and are being incorporated into other health care related legislation.

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Medicaid

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

In addition, effective October 1, 2007, CMS promulgated new rules under the Deficit Reduction Act of 2005, or DRA, changing the federal upper payment limit for Medicaid reimbursement from 150% of the lowest published price for a drug (which is usually the average wholesale price) to 250% of the lowest Average Manufacturer Price, or AMP. Although the use of an AMP benchmark would have reduced Medicaid reimbursement rates for certain generic pharmaceuticals, it did not take effect due to a December 19, 2007 federal district court injunction against CMS prohibiting the agency from implementing the rule. The outcome of the AMP litigation is uncertain, and there can be no assurance that changes in reimbursement formula under the DRA or future legislation or regulation will not have an adverse impact on our business and results of operations. MIPPA delayed the possible use of AMP in setting the Federal Upper Limit (FULs) for multiple source drugs through September 30, 2009, and delayed public posting of AMP data until October 1, 2009. The use of AMP in FULs and public posting of AMP data are currently on hold due to the injunction. Further, several current legislative proposals make significant changes to the AMP and FUL calculations and data. It is unclear if and when these changes will be implemented and thus we cannot fully evaluate the potential impact on our business.

Additionally, OIG recently released a report comparing the relative pharmacy reimbursements amounts for select drugs under Medicare Part D and Medicaid in select states. The OIG found that national reimbursement amounts were roughly equal for single-source drugs, but that the Medicaid pharmacy reimbursement amount for select multiple-source drugs was 17 percent higher than Medicare Part D reimbursement for those same drugs. In addition, the report states that Medicaid dispensing fees exceeded Medicare Part D dispensing fees for both single-source and multiple-source drugs by at least 40 percent and 55 percent, respectively. The report repeatedly notes that these disparities would likely be remedied by the DRA provisions related to AMP that are not yet in use due to the aforementioned injunction. We are unable to fully evaluate the impact of current and future federal initiatives aimed at eliminating these disparities.

Further, the Tax Relief and Health Care Act of 2006 modified several Medicaid policies, including, among other things, reducing the limit on Medicaid provider taxes from the current six percent to five-and-a-half percent from January 1, 2008 through September 30, 2010.

Other

Average wholesale price, or AWP, is a pricing benchmark published by First DataBank, Inc. in its Blue Book, that provides drug databases, content integration software, and drug reference products. AWP has been widely used to calculate a portion of the Medicaid and Medicare Part D drug reimbursements payable to pharmacy providers. In 2005, several pension funds brought an action against First DataBank and another healthcare provider alleging collusion to set AWPs for branded drugs.

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On March 30, 2009, the Court approved the settlement of the litigation. Pursuant to the settlement, First DataBank: (i) adjusted its reporting of Blue Book AWP for those prescription drugs (approximately 1,400 National Drug Codes, or NDCs in number) identified in the plaintiffs previously filed complaint by reducing the mark-up factor utilized in connection with the calculation of the Blue Book AWP data field to 1.20 times the Wholesale Acquisition Cost, or WAC, or direct price for those prescription drugs that are on a mark-up basis; and (ii) established a centralized data repository to facilitate reasonable access to discoverable material from First DataBank concerning its drug price reporting practices. The price adjustment required under the provisions of the settlement agreement occurred on September 26, 2009. Although some appeals are pending, the court has rejected most of these appeals.

Independent of the settlement and on the same schedule as the Blue Book AWP adjustment noted above, First DataBank intends to apply the same 1.20 markup factor to all NDCs whose Blue Book AWP is set based upon a markup to WAC or direct price in excess of 1.20 times WAC. First DataBank will also independently discontinue publishing the Blue Book AWP data field for all drugs no later than two years following the date that the Blue Book AWP adjustments noted above are implemented.

The Corporation and the vast preponderance of the Corporation s PDP s, third party insurance companies and its Medicare Part A customers have voluntarily agreed to adjust reimbursement so that pricing could not increase or decrease as a result of the changes to AWP; however, the state Medicaid programs have been unwilling to remain price neutral and accordingly the Corporation is being reimbursed based on the adjusted AWP. As a result, we believe the AWP settlement will adversely impact our revenues approximately $6.0 million on an annual basis. This exposure is primarily related to the states in which the Corporation operates, who have refused to adjust their Medicaid reimbursement. The National Association of Chain Drug Stores and the National Community Pharmacists Association, the industry trade groups, have filed lawsuits against several state Medicaid programs to force the state Medicaid programs to agree to price neutrality. These cases are still pending.

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

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

Environmental Matters

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

Available Information

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

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

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

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Item 1A. Risk Factors

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

Risk Factors Relating to the Pharmacy Transaction

The integration of the remaining pharmacy locations and systems infrastructure will be time consuming and could have a material adverse effect on our results of operations.

We will continue our information systems integration to one operating platform which will continue to be time consuming, may distract our management from our operations, may be disruptive to our customers and will be expensive, all of which could have a material adverse effect on our results of operations.

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

Before the Pharmacy Transaction, our business was part of two separate public companies. Our former parent companies performed many corporate functions at costs that are less than those that are presently being charged. After the Pharmacy Transaction, AmerisourceBergen continues to be our primary drug distributor under the Prime Vendor Agreement and Kindred provides information technology services under the Information Technology Services Agreement. These agreements were entered into as part of the Pharmacy Transaction and have multi-year terms. During the terms of these agreements, we are not able to negotiate potentially better pricing and other more favorable terms with other vendors thus these existing agreements could negatively impact our results of operations, financial position and competitive position.

Risk Factors Relating to Our Business

Future volatility and disruption to the global capital and credit markets may adversely affect our results of operations and financial condition, as well as our ability to access credit and the financial soundness of our customers and suppliers.

The global capital and credit markets have been experiencing a period of unprecedented turmoil and upheaval, characterized by the bankruptcy, failure, collapse or sale of various financial institutions and an unprecedented level of intervention from the United States federal government. These conditions could adversely affect the demand for our products and services and, therefore, reduce purchases by our customers, which would negatively affect our revenue growth and cause a decrease in our profitability. In addition, interest rate fluctuations, financial market volatility or credit market disruptions may limit our access to capital, and may also negatively affect our customers and our suppliers ability to obtain credit to finance their businesses on acceptable terms. As a result, our customers needs and ability to purchase our products or services may decrease, and our suppliers may increase their prices, reduce their output or change their terms of sale. If our customers or suppliers operating and financial performance deteriorates, or if they are unable to make scheduled payments or obtain credit, our customers may not be able to pay, or may delay payment of, accounts receivable owed to us, and our suppliers may restrict credit or impose different payment terms. Any inability of customers to pay us for our products and services, or any demands by suppliers for different payment terms, may adversely affect our earnings and cash flow. Additionally, both state and federal government sponsored payers, as a result of budget deficits or reductions, may seek to reduce their health care expenditures by renegotiating their contracts with us. Any reduction in payments by such government sponsored payers may adversely affect our earnings and cash flow. Declining economic conditions may also increase our costs. Economic conditions could adversely affect our results of operations or financial condition.

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Intense competition may erode our profit margins.

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

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

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

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

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

If several of these contractual relationships are terminated or materially altered by the pharmaceutical manufacturers, our business and financial results could be materially adversely affected. In addition, formulary fee programs have been the subject of debate in federal and state legislatures and various other public and governmental forums. Changes in existing laws or regulations or in interpretations of existing laws or regulations or the adoption of new laws or regulations relating to any of these programs may materially adversely affect our business.

Our operating revenue and profitability may suffer upon the loss of large multi-facility customers.

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

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

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

Pharmaceutical products can develop unexpected safety or efficacy concerns.

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

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

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

Medicare Part D

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

Risks related to manufacturer rebates

Our pharmacies receive rebates from pharmaceutical manufacturers for undertaking certain activities that the manufacturers believe may increase the likelihood that their respective products will be dispensed. CMS has questioned whether long-term care pharmacies should be permitted to receive discounts, rebates and other price concessions from pharmaceutical manufacturers with respect to prescriptions covered under the Medicare Part D benefit. CMS requires Plan Sponsors to report prescription volume and prescription cost for long-term care pharmacies. As such, most Plan Sponsors require disclosure from us of discounts, rebates or other remuneration received from drug manufacturers. It is possible that these disclosure requirements and others imposed by CMS could have an adverse effect on our business and results of operations. Our business would be adversely affected if CMS should take any action that has the effect of eliminating or significantly reducing the rebates that we receive from pharmaceutical manufacturers.

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Changes in Medicaid Reimbursement

In addition, effective October 1, 2007, CMS promulgated new rules under the Deficit Reduction Act of 2005, or DRA changing the federal upper payment limit for Medicaid reimbursement from 150% of the lowest published price for a drug (which is usually the average wholesale price) to 250% of the lowest average manufacturer price, or AMP. Although the use of an AMP benchmark would have reduced Medicaid reimbursement rates for certain generic pharmaceuticals, it did not take effect due to a December 19, 2007 federal district court injunction against CMS prohibiting the agency from implementing the rule. The outcome of the AMP litigation is uncertain. We are unable to fully evaluate the potential impact until a final action is ultimately determined. There can be no assurance that changes in reimbursement formula under the DRA or future legislation or regulation will not have an adverse impact on our business and results of operations.

The Medicare Improvement for Patients and Providers Act of 2008 delayed use of AMP in setting FULs for multiple source drugs through September 30, 2009, and delayed public posting of AMP data until October 1, 2009. As stated above, the use of AMP in FULs and public posting of AMP data are currently on hold due to an injunction.

The settlement by First DataBank, Inc. on pricing benchmark may reduce reimbursement to us.

Average wholesale price, or AWP, is a pricing benchmark published by First DataBank, Inc. in its Blue Book, that provides drug databases, content integration software, and drug reference products. AWP has been widely used to calculate a portion of the Medicaid and Medicare Part D drug reimbursements payable to pharmacy providers. In 2005, several pension funds brought an action against First DataBank and another healthcare provider alleging collusion to set AWPs for branded drugs.

On March 30, 2009, the Court approved the settlement of the litigation. Pursuant to the settlement, First DataBank: (i) adjusted its reporting of Blue Book AWP for those prescription drugs (approximately 1,400 National Drug Codes, or NDCs in number) identified in the plaintiffs previously filed complaint by reducing the mark-up factor utilized in connection with the calculation of the Blue Book AWP data field to 1.20 times the Wholesale Acquisition Cost, or WAC, or direct price for those prescription drugs that are on a mark-up basis; and (ii) established a centralized data repository to facilitate reasonable access to discoverable material from First DataBank concerning its drug price reporting practices. The price adjustment required under the provisions of the settlement agreement occurred on September 26, 2009.

Independent of the settlement and on the same schedule as the Blue Book AWP adjustment noted above, First DataBank intends to apply the same 1.20 markup factor to all NDCs whose Blue Book AWP is set based upon a markup to WAC or direct price in excess of 1.20 times WAC. First DataBank will also independently discontinue publishing the Blue Book AWP data field for all drugs no later than two years following the date that the Blue Book AWP adjustments noted above are implemented.

The Corporation and the vast preponderance of the Corporation s PDP s, third party insurance companies and its Medicare Part A customers have voluntarily agreed to adjust reimbursement so that pricing could not increase or decrease as a result of the changes to AWP; however, the state Medicaid programs have been unwilling to remain price neutral and accordingly the Corporation is being reimbursed based on the adjusted AWP. As a result, we believe the AWP settlement will adversely impact our revenues approximately $6.0 million on an annual basis. This exposure is limited to the states who are refusing to adjust prices at this time. Currently, the National Association of Chain Drug Stores and the National Community Pharmacists Association, the industry trade groups, have filed lawsuits against several state Medicaid programs to force the state Medicaid programs to agree to price neutrality. These cases are still pending.

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

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

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

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

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

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

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

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The anti-kickback statute and similar state laws and regulations are expansive. We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality, or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial condition, results of operations or prospects and our business reputation could suffer significantly. If we fail to comply with the anti-kickback statute or other applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. In addition, we are unable to predict whether other legislation or regulations at the federal or state level will be adopted, what form such legislation or regulations may take or their impact.

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

We could be adversely affected by the continuing efforts of government and private payers to contain healthcare costs. To reduce healthcare costs, payers seek to lower reimbursement rates, limit the scope of covered services and negotiate reduced or capped pricing arrangements. While many of the proposed policy changes would require congressional approval to implement, we cannot assure you that reimbursement payments under governmental and private third party payer programs will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement under these programs. Any changes that lower reimbursement rates under Medicare, Medicaid or private pay programs could result in a substantial reduction in our net operating revenues. Our operating margins may continue to be under pressure because of deterioration in reimbursement, changes in payer mix and growth in operating expenses in excess of increases, if any, in payments by third party payers.

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

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

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

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

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

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Further, both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the healthcare area. The OIG and the U.S. Department of Justice have, from time to time, established national enforcement initiatives, targeting all providers of a particular type, that focus on specific billing practices or other suspected areas of abuse. In addition, under the federal False Claims Act, private parties have the right to bring qui tam whistleblower lawsuits against companies that submit false claims for payments to the government. A number of states have adopted similar state whistleblower and false claims provisions. We do not believe that we have taken any actions that could subject us to material penalties under these provisions.

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

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

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

We currently earn rebates from certain manufacturers of pharmaceutical products for meeting tiered market share and purchase volumes. There can be no assurance that pharmaceutical manufacturers will continue to offer these rebates or that we will continue to satisfy the tiered market share and purchase volumes. A decrease in the volume of prescriptions dispensed or an increase in the generic dispensing rate could affect our ability to satisfy our manufacturers rebate programs. The termination of such programs or our failure to satisfy the tiered market share and volumes may have an adverse affect on our cost of goods sold and our financial position, results of operations and liquidity.

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

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

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While we believe that we are in substantial compliance with all applicable laws, many of the regulations applicable to us, including those relating to marketing incentives offered by pharmaceutical suppliers, and rebates paid by pharmaceutical manufacturers are vague or indefinite and have not been interpreted by the courts. They may be interpreted or applied by a prosecutorial, regulatory or judicial authority in a manner that could require us to make changes in our operations. These changes may be material and may require the expenditure of material funds to implement. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. Federal and state governments continue to impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bans on Medicare and Medicaid payments and fines. If we or our customers fail to comply with the extensive applicable laws and regulations, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations regardless of whether we have actually been involved in any violations or wrong-doing.

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

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

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

We have made and anticipate that we may continue to make acquisitions of, investments in and strategic alliances with complementary businesses to enable us to capitalize on our position in the geographic markets in which we operate and to expand our businesses in new geographic markets. At any particular time, we may be in various stages of assessment, discussion and negotiation with regard to one or more potential acquisitions, investments or strategic alliances, not all of which, if any, will be consummated. Our growth plans rely, in part, on the successful completion of future acquisitions. If we are unsuccessful, our business would suffer.

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

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

failure to operate acquired facilities profitably or to achieve improvements in their financial performance.

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If we fail to comply with our Corporate Integrity Agreement, we could be subject to severe sanctions, including stipulated monetary penalties and exclusion from federal healthcare programs.

We are subject to the terms of a CIA, entered into between the OIG and PharMerica LTC on March 29, 2005. In June 2004, the OIG commenced an administrative action against PharMerica LTC, including its subsidiary PharMerica Drug Systems, Inc., or PDSI. The OIG alleged that PDSI s December 1997 acquisition of Hollins Manor I, LLC, or Hollins, from HCMF Corporation, or HCMF, violated the anti-kickback provisions of the Social Security Act. The Hollins acquisition predated the acquisition of PharMerica LTC in 1999 by AmerisourceBergen s predecessor. Hollins was an institutional pharmacy that had been established to serve the nursing homes then operated by HCMF. As part of the settlement, in which PharMerica LTC and PDSI expressly denied wrongdoing, PharMerica LTC paid $5.8 million to the HHS and entered into a five-year CIA. In turn, the OIG provided PharMerica LTC and its subsidiaries with a full release for the conduct covered by the administrative action, including an agreement not to pursue their exclusion from participation in Medicare, Medicaid or other federal healthcare programs. Under the CIA, PharMerica LTC agreed to continue its, and the Corporation as of the closing of the Pharmacy Transaction has agreed to maintain a comprehensive compliance program, which includes a corporate compliance officer, a corporate compliance committee, a Code of Ethics and Business Conduct, written policies and procedures, educational and training initiatives, review and disciplinary procedures, a confidential disclosure program, an ineligible persons screening program and internal audit and review procedures, all designed to promote compliance with applicable laws, including federal healthcare program requirements, and the promotion of ethical business practices. PharMerica LTC is also subject to extensive reporting requirements under the CIA, including annual reports describing PharMerica LTC s compliance activities, notices of any government investigations or legal proceedings, overpayments received from federal healthcare programs and changes in pharmacy locations and new business units. The term of the CIA is five years and it ends on March 29, 2010. PharMerica LTC is required to comply fully and timely with all of the CIA requirements. Failure to do so may lead to the imposition of stipulated penalties, including substantial monetary penalties and exclusion from participation in federal healthcare programs, including Medicare and Medicaid. Any such penalties could have a material adverse effect on our financial position, results of operations and liquidity.

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

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

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

We are required to purchase 95% of our pharmaceutical products from AmerisourceBergen, one of our former parent companies, pursuant to the Prime Vendor Agreement. If the Prime Vendor Agreement is terminated or AmerisourceBergen fails to deliver products in accordance with the Prime Vendor Agreement, there can be no assurance that our operations would not be disrupted or that we could obtain the products at similar cost or at all. In this event, failure to satisfy our customers requirements would result in defaults under these customer contracts subjecting us to damages and the potential termination of those contracts. Such events could have a material adverse effect on our financial position, results of operations and liquidity. In addition, under the terms of the Prime Vendor Agreement, we are unable to negotiate potentially better pricing and other terms with other drug distributors which could negatively impact our competitive position.

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

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

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

We have $90.8 million of recorded intangible assets, net, on our consolidated balance sheet as of December 31, 2009. Our intangible assets primarily represent the value of client relationships that were recorded from acquisitions prior to July 31, 2007 and upon our acquisition of PharMerica LTC along with subsequent acquisitions in 2008 and 2009. Under current accounting rules, intangible assets are amortized over their useful lives. These assets may become impaired with the loss of significant clients. If the carrying amount of the assets exceeds the undiscounted pre-tax expected future cash flows from the lowest appropriate asset grouping, we would be required to record a non-cash impairment charge to our statement of operations in the amount the carrying value of these assets exceeds the undiscounted expected future cash flows. In addition, while the intangible assets may not be impaired, the useful lives are subject to continual assessment, taking into account historical and expected losses of relationships that were in the base at time of acquisition. This assessment may result in a reduction of the remaining weighted average useful life of these assets, resulting in potentially significant increases to non-cash amortization expense that is charged to our consolidated statement of operations. An intangible asset impairment charge, or a reduction of amortization lives, could have an adverse effect on our results of operations. For the year ended December 31, 2008, we incurred a pre-tax impairment charge of $14.8 million or $0.30 earnings per diluted share as a result of a review of our lost customer base of pre-Pharmacy Transaction assets.

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

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

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

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

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

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

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

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

- as a result of the risk factors listed in this document;
- actual or anticipated fluctuations in our results of operations;
- for reasons unrelated to our specific performance, such as reports by industry analysts, investor perceptions, or negative announcements by our customers or competitors regarding their own performance;
- regulatory changes that could impact our business or that of our customers; and
- general economic and industry conditions.

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

Certain provisions of our certificate of incorporation and bylaws and provisions of Delaware law as well as certain provisions of agreements entered into in connection with the Pharmacy Transaction could delay or prevent a change of control that stockholders favor.

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

- prohibit stockholder action except at an annual or special meeting. Specifically, this means our stockholders will be unable to act by written consent;

regulate how stockholders may present proposals or nominate directors for election at annual meetings of stockholders. Advance notice of such proposals or nominations will be required;

regulate how special meetings of stockholders may be called. Our stockholders will not have the right to call special meetings;

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authorize our board of directors to issue preferred stock in one or more series, without stockholder approval. Under this authority, our board of directors could adopt a rights plan which could ensure continuity of management by rendering it more difficult for a potential acquirer to obtain control of us; and

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

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

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

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

We are exposed to interest rate changes.

We are exposed to market risk related to changes in interest rates. As of December 31, 2009, we had outstanding debt of $240.0 million, all of which was subject to variable rates of interest. See Item 7, Management s Discussion and Analysis of Financial Condition and Results of Operations Market Risk.

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

We have $240.0 million in indebtednesses outstanding under our senior secured credit facility.

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

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

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

We anticipate that future earnings will be used principally to support operations and finance the growth of our business. Thus, we do not intend to pay dividends or other cash distributions on our common stock in the foreseeable future. See Dividend Policy . We entered into a senior secured credit facility providing for both term and revolving credit borrowings.

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

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

Item 1B. Unresolved Staff Comments

None.

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Item 2. Properties

We have facilities including offices and key operating facilities (e.g. institutional pharmacies) in various locations throughout the United States. The Corporation s corporate headquarters are located in Louisville, Kentucky. In addition to the institutional pharmacies listed below, the Corporation also has four facilities throughout the nation with several overhead and administrative functions. As of December 31, 2009, all facilities were leased. We consider all of these facilities to be suitable, adequate, and are utilized at full capacity by the institutional pharmacy business segment.

The following table presents certain information with respect to operating leases of our institutional pharmacies identified by the Corporation as properties as of December 31, 2009:

Property	# of Facilities	Square Footage	Property	# of Facilities	Square Footage
Alabama	2	20,330	Minnesota	1	15,264
Arizona	2	19,288	Mississippi	1	11,600
Arkansas	1	6,850	Missouri	1	4,090
California	11	109,218	Montana	1	2,440
Colorado	2	14,067	Nebraska	1	5,120
Connecticut	1	15,600	Nevada	2	10,860
Delaware	1	15,600	New Hampshire	1	7,500
Florida	9	94,982	New Mexico	1	4,798
Georgia	2	32,800	North Carolina	4	26,950
Hawaii	5	15,008	Ohio	3	22,051
Idaho	1	5,750	Pennsylvania	9	59,388
Illinois	1	15,256	Rhode Island	1	7,800
Indiana	1	23,724	South Dakota	2	12,050
Iowa	2	10,342	Tennessee	3	28,862
Kansas	1	9,977	Texas	8	62,860
Kentucky	2	43,500	Utah	1	8,002
Louisiana	1	4,914	Virginia	3	23,647
Maine	1	10,200	Washington	2	14,792
Maryland	1	10,744	West Virginia	1	8,000
Massachusetts	2	59,358	Wisconsin	1	10,700
Michigan	2	13,185			

Item 3. Legal Proceedings

From time to time, we are involved in legal and regulatory proceedings. While it is not possible to determine the ultimate disposition of the various ongoing proceedings and whether they will be resolved in our favor, we do not believe that the outcome of these proceedings, individually or in the aggregate, will have a material adverse effect on our financial condition, results of operations or liquidity.

Item 4. Submission of Matters to a Vote of Security Holders

None.

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PART II

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

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

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

	High	Low	Close
Fiscal 2008			
First Quarter	$ 17.17	$ 13.15	$ 16.57
Second Quarter	$ 23.18	$ 15.58	$ 22.59
Third Quarter	$ 25.05	$ 21.59	$ 22.49
Fourth Quarter	$ 22.19	$ 13.70	$ 15.67
Fiscal 2009			
First Quarter	$ 19.38	$ 14.51	$ 16.64
Second Quarter	$ 19.86	$ 15.99	$ 19.63
Third Quarter	$ 21.47	$ 18.57	$ 18.57
Fourth Quarter	$ 18.49	$ 14.59	$ 15.88

As of January 29, 2010, we had approximately 2,740 stockholders of record of the Corporation s common stock.

Stock Performance Graph

The following graph compares the cumulative total return on a $100 investment in each of the Common Stock of the Corporation, the Standard & Poor s 500 Stock Index, the Standard & Poor s 600 Index and the Standard & Poor s Healthcare Index for the period from August 1, 2007 to December 31, 2009. This graph assumes an investment in the Corporation s common stock and the indices of $100 on August 1, 2007 and that all dividends were reinvested:

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	PharMerica Corporation	S&P 500	S&P 600	S&P Healthcare	PMC Peer Group - 2008
August 1, 2007	$ 100	$ 100	100	$ 100	$ 100
September 30, 2007	86	104	104	104	98
December 31, 2007	80	100	104	104	101
March 31, 2008	96	90	89	92	91
June 30, 2008	131	87	89	90	95
September 30, 2008	130	79	88	90	106
December 31, 2008	91	62	65	79	90
March 31, 2009	96	54	54	72	70
June 30, 2009	114	63	65	78	80
September 30, 2009	108	72	77	85	93
December 31, 2009	92	76	81	92	103

During 2009, the Corporation changed its peer group comparison to the S&P Healthcare Index and also included the S&P 600 Index, as management feels the Healthcare Index is a more comprehensive overview of the industry.

The PMC Peer Group - 2008 index includes the following companies: Amedisys Inc., Gentiva Health Services, Inc., Catalyst Health Solutions, Inc., Health South Corporation, Henry Schein, Inc., Invacare Corporation, Lincare Holdings, Inc., Magellan Health Services Inc., Omnicare Inc., Owens & Minor, PSS World Medical Inc., and Res Care, Inc.

The Corporation has never paid a cash dividend on its common stock and does not expect to pay cash dividends on its common stock in the foreseeable future. Our Senior Secured Credit Facility also limits our ability to declare and pay dividends or other distributions on our shares of common stock. Management believes the stockholders are better served if all of the Corporation s earnings are retained for expansion of the business. The Corporation did not repurchase any of the shares of its common stock during the year ended December 31, 2009.

Amended and Restated 2007 Omnibus Incentive Plan

On July 12, 2007, the Corporation adopted the PharMerica Corporation 2007 Omnibus Incentive Plan (as amended and restated, the Omnibus Plan) under which the Corporation is authorized to grant equity-based and other awards to its employees, officers, directors, and consultants. The Corporation has reserved 3,800,000 shares of its common stock for awards to be granted under the Omnibus Plan plus 534,642 shares reserved for substitute equity awards for employees of KPS and PharMerica LTC whose awards were cancelled or forfeited upon the consummation of the Pharmacy Transaction. The Corporation s Compensation Committee administers the Omnibus Plan and has the authority to determine the recipient of the awards, the types of awards, the number of shares covered, and the terms and conditions of the awards. The Omnibus Plan allows for grants of incentive stock options, non-qualified stock options, stock appreciation rights, restricted stock and restricted stock units, deferred shares, performance awards, including cash bonus awards, and other stock-based awards. The Compensation Committee establishes long-term and short-term incentive programs under the Omnibus Plan. On July 24, 2008, the Corporation s stockholders approved an amendment to the Omnibus Plan to provide the Compensation Committee with increased flexibility to use non-GAAP measures to measure performance, including the ability to exclude from the performance measures certain items or charges related to an event or occurrence that the Compensation Committee determines should be excluded in accordance with the performance criteria of performance awards granted pursuant to the Omnibus Plan. In connection with the Corporation s 2009 Annual Meeting of Stockholders, the stockholders of the Corporation approved and adopted the amended and restated Omnibus Plan to preserve preferential tax treatment as qualified performance-based compensation under Section 162(m) of the Code.

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The stock options granted under the Omnibus Plan to replace options granted by Kindred or AmerisourceBergen that were cancelled or forfeited upon the consummation of the Pharmacy Transaction have the same basic terms, conditions, and vesting schedule of the awards granted to them by Kindred and AmerisourceBergen. In addition, unvested restricted shares of Kindred and AmerisourceBergen common stock held by our named executive officers who were formerly KPS or PharMerica LTC employees were replaced with restricted shares of the Corporation s common stock, which have the same basic terms, conditions, and vesting schedule as applied to the forfeited Kindred or AmerisourceBergen restricted shares.

Stock options granted to officers and employees under the Omnibus Plan generally vest in four equal annual installments and have a term of seven years. The restricted stock granted to officers and employees under the Omnibus Plan generally vest in full upon the three-year anniversary of the date of grant. The restricted stock grant to members of the board of directors vest in three equal annual installments. The restricted stock units granted to officers and employees under the Omnibus Plan generally vest in two equal annual installments. The performance share units granted under the Omnibus Plan generally vest based upon the achievement of a target amount of the Corporation s earnings before interest, income taxes, depreciation and amortization, integration, merger and acquisition related costs and other charges, impairment of intangible assets, and any changes in accounting principles, which reinforces the importance of achieving the Corporation s profitability objectives. The performance is measured over a three-year period.

Recent Sales of Unregistered Securities

None.

Recent Purchases of Equity Securities by the Issuer and Affiliated Purchases

None.

Equity Compensation Plan Information

The following table sets forth equity compensation plan information:

Plan Category	Number of securities to be issued upon exercise of outstanding options and rights (a)	Weighted-average exercise price of outstanding options and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by stockholders	2,041,500(1)	$15.60(2)	1,443,127

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

(1) Includes the following:

1,733,325 shares of common stock to be issued upon exercise of outstanding stock options granted under the Omnibus Plan;

208,843 shares of common stock to be issued upon vesting of performance share units under the Omnibus Plan; and

99,332 shares of common stock to be issued upon vesting of restricted stock units under the Omnibus Plan.

(2) The weighted average exercise price in column (b) does not take the 308,175 shares of common stock to be issued under performance share units and restricted stock units into account.

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Item 6. Selected Financial Data

Selected Financial Data

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

	Years Ended December 31,				
	2005 (1)	2006 (1)	2007 (1)(5)	2008	2009
Statement of operations data:					
Revenues	$ 522.2	$ 652.6	$ 1,217.8	$ 1,947.3	$ 1,841.2
Cost of goods sold	439.1	557.9	1,044.0	1,662.7	1,568.9
Gross profit	83.1	94.7	173.8	284.6	272.3
Selling, general and administrative	46.6	67.3	169.3	214.1	187.6
Amortization expense	2.2	3.4	5.0	6.5	9.0
Impairment of intangible assets				14.8	
Integration, merger and acquisition related costs and other charges		2.9	29.8	26.7	5.2
Operating income (loss) (2)	$ 34.3	$ 21.1	$ (30.3)	$ 22.5	$ 70.5
Net income (loss)	$ 21.0	$ 12.8	$ (24.1)	$ 5.0	$ 42.2
Earnings (loss) per common share: (3)					
Basic	NM	NM	$ (1.13)	$ 0.17	$ 1.39
Diluted	NM	NM	$ (1.13)	$ 0.17	$ 1.39
Shares used in computing earnings (loss) per common share:					
Basic	NM	NM	21.3	30.1	30.3
Diluted	NM	NM	21.3	30.2	30.4
Balance sheet data:					
Cash and cash equivalents	$ 1.4	$ 3.7	$ 32.0	$ 41.3	$ 51.2
Working capital	$ 72.3	$ 79.2	$ 268.6	$ 272.3	$ 312.8
Goodwill	$ 40.0	$ 45.2	$ 111.3	$ 113.7	$ 140.1
Intangible assets, net	$ 34.3	$ 38.0	$ 77.5	$ 73.4	$ 90.8
Total assets	$ 194.6	$ 236.8	$ 680.1	$ 679.2	$ 724.3
Long-term debt	$	$	$ 250.0	$ 240.0	$ 240.0
Total stockholder s equity	$ 170.4	$ 198.3	$ 309.2	$ 319.8	$ 370.9
Supplemental information:					
Adjusted EBITDA (4)	$ 40.1	$ 32.8	$ 44.5	$ 92.5	$ 102.7
Adjusted EBITDA Margin (4)	7.7%	5.0%	3.7%	4.8%	5.6%
Adjusted EBITDA per prescription dispensed (4)	$ 3.90	$ 2.59	$ 1.80	$ 2.29	$ 2.63
Net cash provided by operating activities	$ 5.3	$ 10.0	$ 36.3	$ 65.7	$ 85.0
Net cash used by investing activities	$ (109.5)	$ (25.0)	$ (22.0)	$ (47.4)	$ (76.1)
Net cash provided by (used in) financing activities	$ 103.6	$ 17.3	$ 14.0	$ (9.0)	$ 1.0
Statistical information (in whole numbers except where indicated)					
Institutional Pharmacy					
Volume information:					
Prescriptions dispensed (in thousands)	10,289	12,644	24,751	40,319	39,037
Revenue per prescription dispensed	$ 46.25	$ 47.63	$ 46.99	$ 46.85	$ 45.72
Gross profit per prescription dispensed	$ 7.03	$ 6.65	$ 6.57	$ 6.78	$ 6.76
Institutional pharmacy gross margin	15.2%	14.0%	14.0%	14.5%	14.8%
Generic drug dispensing rate	NA	NA	67.4%	70.7%	74.2%
Customer licensed beds under contract:					
Beginning of period	66,195	93,282	102,571	337,043	322,376

Additions	34,174	19,567	260,376	21,398	35,921
Losses and other	(7,087)	(10,278)	(25,904)	(36,065)	(40,412)
End of period	93,282	102,571	337,043	322,376	317,885
Hospital management contracts serviced	73	81	86	84	86

(1) The historical periods of the Corporation exclude the results of PharMerica LTC for the years ended December 31, 2005 and 2006. For the year ended December 31, 2007, PharMerica LTC is included beginning August 1, 2007. See Notes 1 and 2 of Notes to Consolidated Financial Statements.
(2) Includes depreciation expense of $3.6 million, $5.4 million, $15.6 million, $22.0 million and $18.0 million for the years ended December 31, 2005, 2006, 2007, 2008 and 2009, respectively.
(3) The Corporation has never declared a cash dividend. Earnings (loss) per share in whole dollars and cents.
(4) See Use of Non GAAP Measures for Measuring Annual Results for a definition and reconciliation of Adjusted EBITDA to net income and Adjusted EBITDA Margin.
(5) For the year ended December 31, 2007, the Corporation has reclassified $27.9 million from Integration, Merger and acquisition related costs and other charges to bad debt expense, as a component of selling, general and administrative expenses.

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Use of Non-GAAP Measures For Measuring Annual Results

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

Reconciliation of Net Income (Loss) to Adjusted EBITDA

	Years Ended December 31,				
	2005	**2006**	**2007**	**2008**	**2009**
Net income (loss)	$ 21.0	$ 12.8	$ (24.1)	$ 5.0	$ 42.2
Add:					
Interest expense, net		(0.1)	7.2	14.2	9.4
Integration, merger and acquisition related costs and other charges		2.9	29.8	26.7	5.2
Provision (benefit) for income taxes	13.3	8.4	(13.4)	3.3	18.9
Effect of change in estimate on cost of goods sold			(3.1)		
Effect of change in estimate on allowance for doubtful accounts			27.9		
Impairment of intangible assets				14.8	
Depreciation and amortization expense	5.8	8.8	20.2	28.5	27.0
Adjusted EBITDA	$ 40.1	$ 32.8	$ 44.5	$ 92.5	$ 102.7
Adjusted EBITDA Margin	7.7%	5.0%	3.7%	4.8%	5.6%

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Reconciliation of Adjusted EBITDA to Net Operating Cash Flows

	Years Ended December 31,				
	2005	2006	2007	2008	2009
Adjusted EBITDA	$ 40.1	$ 32.8	$ 44.5	$ 92.5	$ 102.7
Interest expense, net		0.1	(7.2)	(14.2)	(9.4)
(Provision) benefit for income taxes	(13.3)	(8.4)	13.4	(3.3)	(18.9)
Effect of change in estimate on cost of goods sold			3.1		
Effect of change in estimate on allowance for doubtful accounts			(27.9)		
Integration, merger and acquisition related costs and other charges		(2.9)	(22.6)	(22.2)	(4.8)
Provision for bad debt	(1.1)	7.3	44.1	24.7	16.6
Stock-based compensation	0.8	0.9	1.5	4.9	4.6
Amortization of deferred financing fees			0.2	0.4	0.4
Loss on disposition of equipment		0.5	0.1	0.2	0.3
Deferred income taxes	(2.0)	(1.6)	(13.4)	2.8	19.7
Other	(1.1)	(3.5)	(0.9)	(0.5)	(0.3)
Changes in assets and liabilities	(18.1)	(15.2)	1.4	(19.6)	(25.9)
Net Cash Flows from Operating Activities	$ 5.3	$ 10.0	$ 36.3	$ 65.7	$ 85.0

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

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

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

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

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

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

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

the demand for the Corporation s products and services;

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

the effects of renegotiating contract pricing relating to significant customers, supplier, including the hospital pharmacy segment which is substantially related to service provided to one customer;

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

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

the impact of the First Data Bank settlement agreement on the reimbursement the Corporation receives for its products and services;

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

the effects of healthcare reform and government regulations, including proposals being contemplated by the current administration, interpretation of regulations, and changes in the nature and enforcement of regulations governing the healthcare and institutional pharmacy services industries;

changes in the reimbursement rates or methods of payment from Medicare and Medicaid and other third party payers, or the implementation of other measures to reduce the reimbursement for the Corporation s products and services or the services of the Corporation s customers or the Corporation s Medicare business covered by specific contracts;

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

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

the ability to obtain financing for acquisitions from the various lenders in the senior secured credit facility;

the effects of changes in the interest rate on the Corporation s outstanding floating rate debt instrument and the increases or decreases in interest expense;

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

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

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

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

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

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

the Corporation s ability to comply with the terms of its Corporate Integrity Agreement entered into between the Office of Inspector General of the Department of Health and Human Services and PharMerica LTC on March 29, 2005;

the Corporation s risk of loss not covered by insurance;

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

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

the effects on the Corporation s results of operations related to the accounting for the costs of acquisitions as a result of new accounting rules;

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

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

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

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

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

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

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changes in tax laws and regulations;

the effects of changes to critical accounting estimates; and

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

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

General

Pharmacy Transaction

The Corporation was formed on October 23, 2006 by Kindred and AmerisourceBergen for the purpose of consummating the transactions contemplated by the Master Agreement dated October 25, 2006, as amended. Pursuant to the Master Agreement, Kindred and AmerisourceBergen, through the Pharmacy Transaction, combined their respective institutional pharmacy businesses, KPS and PharMerica LTC, into a new, stand-alone, publicly traded company. The Pharmacy Transaction was consummated on July 31, 2007.

Under the terms of the Pharmacy Transaction, on the Closing Date, each of KPS and PharMerica LTC borrowed $125.0 million as mutually agreed upon by Kindred and AmerisourceBergen and used such proceeds to fund a one-time, tax-free cash distribution in that amount to their respective parent companies. Following the cash distributions, Kindred spun off to its stockholders all of the outstanding stock of KPS and AmerisourceBergen spun off to its stockholders all of the outstanding stock of PharMerica LTC. Immediately thereafter, separate wholly owned subsidiaries of the Corporation were merged with and into KPS and PharMerica LTC with KPS and PharMerica LTC as the surviving entities of the mergers, and, as a result, KPS and PharMerica LTC became wholly owned subsidiaries of the Corporation. The Corporation issued 30 million shares of its common stock in the mergers (see Note 2 to the Corporation s consolidated financial statements). Immediately following such spin-offs and mergers, the stockholders of Kindred and AmerisourceBergen each owned 50% of the outstanding common stock of the Corporation. The shares of the Corporation s common stock held by Kindred and AmerisourceBergen prior to the Pharmacy Transaction were cancelled, and neither retained any ownership of the outstanding shares of common stock of the Corporation.

The Pharmacy Transaction was accounted for using the purchase method of accounting under accounting principles generally accepted in the United States, with KPS treated as the accounting acquirer. Under the purchase method of accounting, the deemed purchase price was allocated to the underlying tangible and identifiable intangible assets and liabilities acquired based upon their respective fair values with any excess deemed purchase price allocated to goodwill. See Note 2 to the Corporation s consolidated financial statements for additional information.

Prior to the closing of the Pharmacy Transaction, the Corporation had no assets or liabilities and conducted no business activity. Prior to the closing of the Pharmacy Transaction, the Corporation s business was operated as separate businesses of two different public companies, Kindred and AmerisourceBergen.

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Reporting Entity

The consolidated financial statements included in this Annual Report on Form 10-K as of December 31, 2008 and 2009 and for the years ended December 31, 2007, 2008 and 2009 reflect the financial position, results of operations and cash flows of the Corporation, which during the first seven months of 2007, KPS was a wholly owned subsidiary of Kindred. As discussed above, the Pharmacy Transaction was accounted for as an acquisition by KPS of PharMerica LTC with KPS being considered the accounting acquirer. As a result, the historical financial statements of KPS have become the historical financial statements of the Corporation. The results of PharMerica LTC are included in the results of operations of the Corporation beginning August 1, 2007. Accordingly, except as otherwise discussed below, this Management s Discussion and Analysis reflects the financial condition, results of operations and cash flows of the Corporation at December 31, 2008, and 2009 and historically of KPS on a stand-alone basis for all periods prior to August 1, 2007.

The Corporation s Business and Industry Trends

The Corporation is an institutional pharmacy services company, which services healthcare facilities and provides management pharmacy services to hospitals. The Corporation is the second largest institutional pharmacy services company in the United States. The Corporation operates 98 institutional pharmacies in 41 states. The Corporation s customers are typically institutional healthcare providers, such as nursing centers, assisted living facilities, hospitals and other long-term alternative care settings. The Corporation is generally the primary source of supply of pharmaceuticals to its customers. The Corporation also provides pharmacy management services to 86 hospitals in the United States.

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

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

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

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Critical Accounting Estimates

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

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

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

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

The table that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate. Our sensitivity analysis was performed assuming the assumptions listed based upon the actual results of the Corporation for the year ended December 31, 2009, and the actual diluted shares:

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Allowance for doubtful accounts and provision for doubtful accounts

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

Our allowances for doubtful accounts, included in our balance sheet at December 31, 2008 and 2009, were $46.5 million and $40.2 million, respectively.

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

	Amount	% of Revenues
2007		
March 31	$ 1.1	0.6%
June 30	3.3	1.9
September 30 (1)	34.2	9.1
December 31	5.5	1.1
2008		
March 31	$ 5.2	1.1%
June 30	5.5	1.1
September 30	7.2	1.5
December 31	6.8	1.4
2009		
March 31	$ 7.1	1.5%
June 30	3.6	0.8
September 30	2.5	0.5
December 31	3.4	0.8

(1) Includes the $27.9 million change in estimate to increase the allowance for doubtful accounts associated with the Pharmacy Transaction.

Assumptions/Approach Used

The largest components of bad debts in our accounts receivable relate to the accounts for which private payers are responsible (which we refer to as private and other), accounts for which our customers from long-term care institutions are responsible for under Medicare Part A and owe us

for the drug component of their patients stay at their respective institution, third party, Medicare Part D, and Medicaid accounts that have been denied.

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

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

- if possible, perform up front adjudication prior to dispensing the product;
- billing and follow-up with third party payers;
- billing and follow-up with long-term care institutions;
- utilization of collection agencies; and
- other legal processes.

We determine the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the allowance for doubtful accounts.

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

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

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

	2007	2008	2009
March 31	41.5	39.7	42.4
June 30	44.4	40.7	42.0
September 30	45.4	41.1	42.1
December 31	40.1	42.0	42.9

Sensitivity Analysis

If our provision as a percent of institutional revenue increases 0.10%, our after tax income would decline by approximately $1.1 million or $0.03 per diluted share.

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

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Allowance for doubtful accounts and provision for doubtful accounts

-(continued)

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

	Allowance	Gross Accounts Receivable	% of Gross Accounts Receivable
2007			
March 31	NM	NM	NM
June 30	NM	NM	NM
September 30	$ 64.6	$ 282.1	22.9%
December 31	43.4	256.4	16.9
2008			
March 31	$ 44.3	$ 261.6	16.9%
June 30	45.2	262.0	17.3
September 30	45.8	266.6	17.2
December 31	46.5	265.8	17.5
2009			
March 31	$ 49.1	$ 267.8	18.3%
June 30	50.4	260.6	19.3
September 30	46.3	261.6	17.7
December 31	40.2	255.5	15.7

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

Assumptions/Approach Used

The following table shows our summarized aging categories by quarter:

	0 to 60 days	61 to 120 days	Over 120 Days
2007			

March 31	NM	NM	NM
June 30	NM	NM	NM
September 30	60.6%	16.5%	22.9%
December 31	64.8	17.4	17.8
2008			
March 31	68.7%	14.2%	17.1%
June 30	63.2	19.7	17.1
September 30	62.0	19.1	18.9
December 31	64.1	18.1	17.8
2009			
March 31	63.1%	17.4%	19.5%
June 30	64.3	17.0	18.7
September 30	63.6	17.1	19.3
December 31	64.9	17.1	18.0

On a monthly basis, the Corporation performs a comprehensive assessment of its reserve levels in light of its expectations around the ultimate collection of its accounts receivable balances. The Corporation considers recent industry trends, changes in reimbursement sources and procedures, age of receivables and recent collection history.

In September 2007, as part of the analysis described above, the Corporation recorded in selling, general and administrative a change in accounting estimate to increase the allowance for doubtful accounts by $27.9 million, resulting in loss per diluted share impact of $0.84.

The change in accounting estimate of $27.9 million representing an increase in the allowance for doubtful accounts is related to the acquired receivables of PharMerica LTC as of July 31, 2007, and is unrelated to the accounts receivable and revenue of KPS. This amount was charged to selling, general and administrative expenses, however, the related revenue had never been recorded in the accounts of either the Corporation or its predecessor entity, KPS.

Sensitivity Analysis

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Revenue recognition/Allowance for contractual discounts

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

Our sources of revenues for the years ended December 31, 2007, 2008, and 2009 are as follows:

	2007	2008	2009
Medicare Part D	45.2%	45.5%	46.3%
Institutional healthcare providers	30.3	29.7	29.6
Medicaid	8.9	9.3	9.0
Private and other	6.4	6.8	6.6
Insured	3.8	5.2	5.0
Medicare	0.9	0.5	0.4
Hospital Management fees	4.5	3.0	3.1
Total	100.0%	100.0%	100.0%

Our sources of revenues for the quarters ended March 31, June 30, September 30, and December 31, 2007, 2008, and 2009 are as follows:

	Three Months Ended March 31,			Three Months Ended June 30,		
	2007	2008	2009	2007	2008	2009
Medicare Part D	43.9%	46.2%	45.9%	41.2%	44.7%	45.5%
Institutional healthcare providers	33.9	29.6	30.1	34.0	30.1	30.1
Medicaid	7.8	9.6	9.3	7.9	9.2	9.2
Private and other	4.8	6.2	6.2	5.2	7.0	6.8
Insured	0.7	4.8	5.0	2.5	5.4	4.9
Medicare	1.2	0.6	0.3	1.3	0.5	0.4
Hospital management fees	7.7	3.0	3.2	7.9	3.1	3.1
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended September 30,			Three Months Ended December 31,		
	2007	2008	2009	2007	2008	2009
Medicare Part D	45.9%	45.1%	45.9%	46.5%	45.9%	48.0%
Institutional healthcare providers	29.1	29.2	29.2	28.7	29.7	29.0
Medicaid	9.1	9.5	9.1	9.6	8.9	8.4
Private and other	7.1	7.3	7.5	6.9	6.9	6.2
Insured	4.5	5.3	5.0	4.9	5.3	5.0
Medicare	0.7	0.6	0.3	0.6	0.4	0.4
Hospital management fees	3.6	3.0	3.0	2.8	2.9	3.0

Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

Assumptions/Approach Used

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

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

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

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

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

Sensitivity Analysis

If our reimbursement declined or was negatively impacted 0.25%, the negative impact on net income would be $2.6 million or $0.09 per diluted share.

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Balance Sheet or Income Statement Caption/ Nature of Critical Estimate Item	
Inventory and cost of drugs dispensed	
We have inventory located at each of our institutional pharmacy locations. The inventory consists of prescription drugs, over the counter products and intravenous solutions. Our inventory relating to controlled substances is maintained on a manually prepared perpetual system to the extent required by the Drug Enforcement Agency. All other inventory is maintained on a periodic system, through the performance of quarterly physical inventories.	
At December 31, 2008 and 2009, our inventory on our consolidated balance sheets was as follows (dollars in millions):	
2008 $73.4	
2009 $79.8	

Our annualized inventory turns were as follows:

	2007	2008	2009
March 31	15.8	16.4	16.7
June 30	16.1	16.1	16.8
September 30	15.9	16.5	16.7
December 31	16.7	16.5	15.8

We receive rebates on purchases from various vendors and suppliers.

Rebates included in our statements of operations were as follows (dollars in millions):

	2007	2008	2009
March 31	$ 4.0	$ 12.7	$ 10.5
June 30	3.8	13.9	11.6
September 30	11.5	12.1	12.9
December 31	12.4	11.9	14.5
Total	$ 31.7	$ 50.6	$ 49.5

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

Assumptions/Approach Used

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

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

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

Sensitivity Analysis

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

A 1.0% error rate in the count of prescription drugs in inventory would negatively impact net income $0.5 million, or $0.02 per diluted share.

If our rebates received were to be reduced by 1.0%, the effect on net income for the year ended December 31, 2009 would have been a decrease of $0.3 million, or $0.01 per diluted share.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Goodwill, other intangible assets and accounting for business combinations

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

Our goodwill included in our consolidated balance sheets as of December 31, 2008 and 2009 was as follows (dollars in millions):

2008 $113.7

2009 $140.1

Our net intangible assets, included in our consolidated balance sheets as of December 31, 2008 and 2009 were as follows (dollars in millions):

	2008	2009
Customer relationships	$ 53.1	$ 76.6
Tradenames	27.9	28.5
Non-competition agreements	2.4	4.7
	83.4	109.8
Accumulated Amortization	(10.0)	(19.0)
	$ 73.4	$ 90.8

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

As a part of the August 10, 2009 institutional pharmacy business acquisition, we have a contingent consideration liability of $1.7 million. This amount is not to exceed $10.0 million in the form of a contingent consideration to be paid at the end of a three year period based upon the cumulative achievement of certain financial performance measures.

Assumptions/Approach Used

We are required to test goodwill for impairment annually, absent some triggering event that would accelerate an impairment test using a fair value approach. We determine fair value using widely accepted valuation techniques, including discounted cash flow and market multiple analyses. These types of analyses require us to make assumptions and estimates regarding future cash flows, industry economic factors and the profitability of future business strategies.

The purchase price of acquisitions are allocated to the assets acquired and liabilities assumed based upon their respective fair values. We engage independent third-party valuation firms to assist us in determining the fair values of assets acquired and liabilities assumed. Such valuations require us to make significant estimates and assumptions, including projections of future events and operating performance.

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

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

For the year ended December 31, 2008, we recognized an impairment charge of $14.8 million related to finite lived intangible assets resulting in a loss per dilutive share impact of $0.30. The impairment, which related to the Institutional Pharmacy segment, was incurred when the reporting unit experienced a higher than expected loss of licensed beds. See Note 4 to our financial statements for further disclosures of the impairment charge.

Sensitivity Analysis

We performed our annual testing for goodwill impairment as of December 31, 2007, 2008, and 2009 using the methodology described here, and determined that no goodwill impairment existed. If actual future results are not consistent with our assumptions and estimates, we may be required to record goodwill impairment charges in the future. Our estimate of fair value of acquired assets and assumed liabilities are based upon assumptions believed to be reasonable based upon current facts and circumstances.

As it relates to the contingent consideration liability, if actual future results are not consistent with our assumptions and estimates, we may be required to record a charge as acquisition costs to the consolidated statement of operations. Our estimate of fair value of the liability is based upon assumptions believed to be reasonable based upon current facts and circumstances. As these facts and circumstance change, our estimate will be adjusted through the income statement.

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Balance Sheet or

Income Statement Caption/

Nature of Critical Estimate Item

Accounting for income taxes

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

We assess the likelihood that deferred tax assets will be recovered from future taxable income. A valuation allowance is provided for deferred tax assets if it is more-likely-than-not that some portion or all of the net deferred tax assets will not be realized. Our deferred tax asset balances in our consolidated balance sheets as of December 31, 2008 and 2009 were as follows (dollars in millions), including the impact of valuation allowances:

2008 $ 84.3

2009 $ 60.8

Our valuation allowances for deferred tax assets in our consolidated balance sheets as of December 31, 2008 and 2009 were as follows (dollars in millions):

2008 $ 10.3

2009 $ 1.7

Significant judgment is required in determining and assessing the impact of uncertain tax positions. For an identified uncertain tax position to qualify for benefit recognition, the position must have at least a more-likely-than-not chance of being sustained on its technical merits if challenged by relevant taxing authorities and taken by management to the court of last resort. If an uncertain position does not meet this recognition threshold based on our analysis of applicable tax law, we establish a liability for the realized, but unrecognized tax benefit. As of December 31, 2009, the Corporation has a $1.6 million liability recorded for unrecognized tax benefits for U.S. federal and state tax jurisdictions. The Corporation records accrued interest and penalties associated with uncertain tax positions as income tax expense in the consolidated statement of operations. We recognize the benefit for an uncertain tax position we have taken upon any one of the following conditions: 1) the recognition threshold is met due to changes in facts, circumstances and information available at the reporting date; 2) the tax position is effectively settled through examination, negotiation or litigation; or 3) the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired.

Please refer to Note 10 to our consolidated financial statements included elsewhere in this report for a detailed discussion of our accounting for income taxes.

Assumptions/Approach Used

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

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

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

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

For the year ended December 31, 2009, the Corporation recorded a tax benefit of $5.7 million ($0.19 per diluted share) for valuation allowance releases related to the adoption of an internal legal entity restructuring plan. Pursuant to the restructuring plan, the Corporation believes that it is more likely than not that it will be able to realize certain historic state net operating loss carryforwards for which a valuation allowance had previously been provided.

Sensitivity Analysis

Our deferred tax assets exceeded our deferred tax liabilities by $60.8 million as of December 31, 2009, including the impact of valuation allowances. Historically, we have produced federal taxable income and we expect to generate taxable income in future years. Therefore, we believe that the likelihood of our not realizing the federal tax benefit of our deferred tax assets is remote.

However, we do have subsidiaries with a history of tax losses in certain state jurisdictions and, based upon those historical tax losses and current expected results, we assumed that the subsidiaries would not be profitable in the future for those states tax purposes unless a strong earnings history existed apart from an identifiable operational condition no longer present. If our assertion regarding the future profitability of those subsidiaries was incorrect, then our deferred tax assets would be understated by the amount of the valuation allowance of $10.3 million and $1.7 million at December 31, 2008 and 2009, respectively.

The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments we would incur additional tax payments for 2009 plus the applicable penalties and interest.

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Balance Sheet or Income Statement Caption/ Nature of Critical Estimate Item	Assumptions/Approach Used
Accounting for stock-based compensation	

On July 12, 2007, the Corporation adopted the PharMerica Corporation 2007 Omnibus Incentive Plan (Omnibus Plan) under which the Corporation is authorized to grant equity-based and other awards to its employees, officers, directors and consultants. The Corporation has reserved 3,800,000 shares of its common stock for awards to be granted under the Omnibus Plan plus 534,642 shares issued for substitute equity awards for employees of KPS and PharMerica LTC whose awards were cancelled or forfeited upon the consummation of the Pharmacy Transaction.

The Compensation Committee has granted stock based compensation awards with respect to 3,293,019 common shares under the Omnibus Plan. After consideration of forfeitures, 1,443,127 shares remain available for grant at December 31, 2009.

The Corporation s Compensation Committee administers the Omnibus Plan and has the authority to determine the recipient of the awards, the types of awards, the number of shares covered and the terms and conditions of the awards. The Omnibus Plan allows for grants of incentive stock options, non-qualified stock options, stock appreciation rights, restricted stock, deferred shares, performance awards, including cash bonus awards, and other stock-based awards. On July 24, 2008, the Corporation s stockholders approved an amendment to the Omnibus Plan to provide the Compensation Committee with increased flexibility to use non-GAAP measures to measure performance, including the ability to exclude from the performance measures certain items or charges related to an event or occurrence which the Compensation Committee determines should be excluded, in accordance with the performance criteria of performance awards granted pursuant to the Omnibus Plan. The Compensation Committee establishes long-term and short-term incentive programs under the Omnibus Plan. In connection with the Corporation s 2009 Annual Meeting of Stockholders, the stockholders of the Corporation approved and adopted the amended and restated Omnibus Plan to preserve preferential tax treatment as qualified performance-based compensation under Section 162(m) of the Code.

Unvested stock option and restricted shares of Kindred and AmerisourceBergen common stock held by our employees who were formerly PharMerica LTC or KPS employees were replaced with stock based awards of the Corporation s common stock, which will have the same terms and conditions as applied to the forfeited Kindred or AmerisourceBergen stock based awards.

Our stock-based compensation for the years ended December 31, 2007, 2008, and 2009 included in our results of operations was as follows (dollars in millions):

2007: $1.5

2008: $4.9

2009: $4.6

Please refer to Note 9 to our consolidated financial statements included elsewhere in this report for a detailed discussion of our accounting for stock-based compensation.

In connection with the granting of shares under the Omnibus plan, each option generally vests in four equal annual installments and to have a term of seven years. The restricted stock will generally vest, in full, upon the three-year anniversary of the date of grant, thus stressing the retentive aspect of these awards. The restricted stock units generally vest in two equal annual installments. The full vesting of performance share units is based upon a target amount of the Corporation s earnings before interest, income taxes, depreciation and amortization, or Adjusted EBITDA performance, which will reinforce the importance of achieving the Corporation s profitability objectives. The performance period for the performance share units is generally a three-year period.

We estimated the fair value of stock options granted during 2007, 2008, and 2009 using the Black Scholes Merton option valuation model (BSM). We are amortizing the fair value on a straight-line basis over the requisite service periods of the awards, which are the vesting periods of three to four years. The stock options that were granted under the Omnibus Plan vest 25% on each grant anniversary date over four years of continued employment. Restricted stock awards vest 100% at the third anniversary.

The weighted average fair value per share of stock options granted by us during 2007, 2008, and 2009 were $5.82, $4.67, and $4.40, respectively. The following table shows the weighted average assumptions we used to develop the fair value estimates under our stock options valuation model for 2007, 2008, and 2009 and the paragraphs below this table summarizes each assumption:

	2007	2008	2009
Expected volatility (range)	33.3 - 45.0%	33.3 - 41.7%	36.36 - 41.07%
Risk free interest rate (range)	4.55 - 4.98%	1.53 - 2.45%	0.75 - 2.09%
Expected dividends			
Average expected term (years)	0.3 - 5.0	2.0 - 5.0	2.0 - 5.0
Fair value per share of stock options granted based on the Black-Sholes-Merton model (dollars)	$5.82	$4.67	$4.40
Weighted average fair value of options granted during the year (in millions)	$6.2	$1.5	$2.5

The Corporation aggregates individual awards into relatively homogeneous groups with respect to exercise and post-vesting employment behaviors for the purpose of refining the expected term assumption, regardless of the valuation technique used to estimate the fair value. We have stratified our employee population into two groups: (i) insiders, who are the Section 16 filers under SEC rules; and (ii) non-insiders, who are the rest of the employee population.

Volatility is a measure of the tendency of investment returns to vary around a long-term average rate. As the Corporation has no history prior to July 31, 2007, we have used historical peer-group volatility. We also consider how future experience may differ from the past. This may require using other factors to adjust historical volatility, such as implied volatility, peer-group volatility and the range and mean-reversion of volatility estimates over various historical periods. The peer-group utilized consisted of fourteen companies in the same or similar industries as the Corporation.

Sensitivity Analysis

The fair value calculations of our stock option grants are affected by assumptions that are believed to be reasonable based upon the facts and circumstances at the time of grant. Changes in our volatility estimates can materially affect the fair values of our stock option grants. If our stock based compensation expense during 2009 was 10% higher, our 2009 after-tax income would decrease by approximately $0.2 million, or $0.01 per diluted share.

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Balance Sheet or Income Statement Caption/ Nature of Critical Estimate Item	Assumptions/Approach Used	Sensitivity Analysis
	In addition, management uses the mean in the range of reasonable estimates for volatility.	
	The risk-free rate is based on the U.S. Treasury yield curve in effect at the time of grant for the estimated life of the option.	
	We have never paid cash dividends on our common stock and do not anticipate paying cash dividends on our common stock in the foreseeable future. Consequently, we use an expected dividend yield of zero.	
	Pre-vesting forfeitures do not affect the fair value calculation, but they affect the expense calculation. The Corporation estimates pre-vesting forfeitures at the time of grant and revises those estimates in subsequent periods if actual forfeitures differ from those estimates. We have estimated pre-vesting option forfeitures and recorded share-based compensation expense only for those awards that are expected to vest.	
	Post-vesting cancellations include vested options that are cancelled, exercised or expire unexercised.	
	The Corporation calculated an expected term using management s estimate of option exercises. The majority of the Corporation s stock options are on a graded-vesting schedule. The Corporation estimates the value of awards with graded vesting by treating each vesting tranche as a separate award. Management has determined to value each tranche of the awards separately utilizing a multiple fair value method.	

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Impact of Recent Accounting Pronouncements

Management reviewed the most recent issued accounting pronouncements as of December 31, 2009 and determined that none were applicable to the Corporation.

Key Financial Statement Components

Consolidated Statements of Operations

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

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

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

Integration, merger and acquisition related costs and other charges represents the costs associated with the spin-offs of Kindred Pharmacy Services and PharMerica LTC from Kindred Healthcare and AmerisourceBergen and their respective mergers. Integration, merger and acquisition related costs and other charges also includes costs of acquisitions subsequent to the Pharmacy Transaction. Effective January 1, 2009, the accounting standards for the accounting of business combinations changed, prior to the adoption of this accounting change, substantially all costs incurred as a result of an acquisition were capitalized as a part of the purchase price of the business combination. The new rules require such costs to be expensed and recorded as a component of the statement of operations.

Interest expense (income), net, primarily includes interest expense relating to our senior secured credit facility and the swap agreement that expired on July 31, 2009, partially offset by interest income generated by cash and cash equivalents.

Consolidated Balance Sheets

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

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

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

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

Deferred tax assets primarily represent temporary differences between the financial statement basis and the tax basis of certain accrued expenses, tax deductible goodwill, ability to utilize net operating loss carryforwards, and stock-based compensation. Fixed assets include investments in our institutional pharmacies and information technology, including capitalized software development. Goodwill and intangible assets are comprised primarily of goodwill and intangibles related to our previous acquisitions.

Our primary liabilities include accounts payable, accrued salaries and wages, other current liabilities, debt, and deferred tax liabilities. Accounts payable primarily consist of amounts payable for prescription inventory purchases under our Prime Vendor Agreement and other purchases made in the normal course of business. The balances in accounts payable and accrued salaries and wages are at the highest on Thursday nights and at the lowest on Friday nights, as a result of payments for drug costs and payroll being made on Friday. Accrued expenses and other current liabilities primarily consist of employee and facility-related cost accruals incurred in the normal course of business, as well as income taxes payable. Our debt is primarily comprised of a loan under our senior secured credit facility. We do not have any off-balance sheet arrangements, other than purchase commitments and lease obligations.

Consolidated Statements of Cash Flows

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

Definitions

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

Assisted Living Facilities (ALF): Represents assisted living facility. Its units or beds will represent the number of apartment type units within the facility.

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

DNA: Represents data not available.

NA: Represents not applicable.

NM: Represents not meaningful.

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

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

Skilled Nursing Facilities (SNF): Represents skilled nursing facilities. Its licensed beds will represent the customer licensed beds and this may not be indicative of its census.

Results of Operations

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

	Years Ended December 31,									
	2007		Increase (Decrease)		2008		Increase (Decrease)		2009	
	Amount	% of Revenues			Amount	% of Revenues			Amount	% of Revenues
Net revenues:										
Institutional Pharmacy	$ 1,163.0	95.5%	$ 725.8	62.4%	$ 1,888.8	97.0%	$ (104.1)	(5.5)%	$ 1,784.7	96.9%
Hospital Management	54.8	4.5	3.7	6.8	58.5	3.0	(2.0)	(3.4)	56.5	3.1
Total net revenues	1,217.8	100.0	729.5	59.9	1,947.3	100.0	(106.1)	(5.4)	1,841.2	100.0
Cost of goods sold:										
Institutional Pharmacy	1,000.3	82.1	615.0	61.5	1,615.3	83.0	(94.4)	(5.8)	1,520.9	82.6
Hospital Management	43.7	3.6	3.7	8.5	47.4	2.4	0.6	1.3	48.0	2.6
Total cost of goods sold	1,044.0	85.7	618.7	59.3	1,662.7	85.4	(93.8)	(5.6)	1,568.9	85.2
Gross profit:										
Institutional Pharmacy	162.7	13.4	110.8	68.1	273.5	14.0	(9.7)	(3.5)	263.8	14.3
Hospital Management	11.1	0.9		0.0	11.1	0.6	(2.6)	(23.4)	8.5	0.5
Total gross profit	$ 173.8	14.3%	$ 110.8	63.8%	$ 284.6	14.6%	$ (12.3)	(4.3)%	$ 272.3	14.8%
Institutional Pharmacy (in whole numbers except where indicated)										
Volume information										
Prescriptions dispensed (in thousands)	24,751		15,568	62.9%	40,319		(1,282)	(3.2)%	39,037	
Revenue per prescription dispensed	$ 46.99		$ (0.14)	(0.3)%	$ 46.85		$ (1.13)	(2.4)%	$ 45.72	
Gross profit per prescription dispensed	$ 6.57		$ 0.21	3.2%	$ 6.78		$ (0.02)	(0.3)%	$ 6.76	
Institutional pharmacy gross margin	14.0%		0.5	3.5%	14.5%		0.3	2.1%	14.8%	
Generic dispensing rate	67.4%		3.3	4.9%	70.7%		3.5	5.0%	74.2%	
Customer licensed beds under contract										
Beginning of period	102,571		234,472	228.6%	337,043		(14,667)	(4.4)%	322,376	
Additions	260,376		(238,978)	(91.8)	21,398		14,523	67.9	35,921	
Losses and other	(25,904)		(10,161)	39.2	(36,065)		(4,347)	12.1	(40,412)	
End of period	337,043		(14,667							