PharMerica CORP
Form 10-K
February 26, 2016
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-K
(Mark One)
ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the year ended December 31, 2015
or
TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to .
Commission File Number: 001-33380

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

Delaware	87-0792558
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

1901 Campus Place Louisville, KY	40299
(Address of Principal Executive Offices)	(Zip Code)

(502) 627-7000
(Registrant's Telephone Number, Including Area Code)
Securities registered pursuant to Section 12(b) of the Act:

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

Securities registered pursuant to Section 12(g) of the Act:
N/A
(Title of class)

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

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

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 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.

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 T	Accelerated filer
Non-accelerated filer	Smaller reporting company
(Do not check if a smaller reporting company)	

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

The aggregate market value of the voting and non-voting common equity of the registrant held by non-affiliates as of June 30, 2015 was $979,005,881.

Class of Common Stock	Outstanding at February 19, 2016
Common stock, $0.01 par value	30,517,083

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates certain information by reference from registrant's definitive proxy statement for the 2016 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, 2015.

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Part I

Item 1. Business

Overview

Formed in 2006, PharMerica Corporation (the "Corporation," "we," "us," or "our"), a Delaware Corporation, is an institutional pharmacy services company that services healthcare facilities, provides pharmacy management services to hospitals, provides specialty infusion services to patients outside a hospital setting, and offers the only national oncology pharmacy in the United States. The Corporation is the second largest institutional pharmacy services company in the United States based on revenues and customer licensed beds under contract, operating 94 institutional pharmacies, 17 specialty infusion centers and 5 specialty oncology pharmacies in 45 states. The Corporation's customers are typically institutional healthcare providers, such as skilled nursing facilities, assisted living facilities, hospitals, individuals receiving in-home care and patients with cancer.

Institutional Pharmacy Business

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

We offer prescription and non-prescription pharmaceuticals to our customers through unit dose or modified unit dose packaging, dispensing, and delivery systems, typically in a 14 to 30 day supply. Unit dose medications are packaged for dispensing in individual doses as compared to bulk packaging used by most retail pharmacies. The customers we serve prefer the unit dose delivery system over the bulk delivery system employed by retail pharmacies because it improves control over the storage and ordering of drugs and reduces errors in drug administration in healthcare facilities. Nursing staff in our customers' facilities administer the pharmaceuticals to individual patients and residents. The Corporation also utilizes an on-site dispensing system, with real time data transfer between the system and the Corporation, which provides timely medication administration in emergency and first dose situations. We also offer clinical pharmacy programs that encompass a wide range of drug therapy and disease management protocols, including protocols for anemia treatment, infectious diseases, wound care, nutritional support, renal dosing, and therapeutic substitution.

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

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 business is comprised of a few customers, of which, our largest service is to the majority of the Kindred Healthcare Inc. ("Kindred") hospitals.

Consultant Pharmacist Services

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

We provide consultant pharmacist services to approximately 67% of our patients serviced. The services offered by our consultant pharmacists include:

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

Medical Records

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

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

Specialty Infusion Services

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

Specialty Oncology Pharmacy

We provide dispensing of oncology drugs, care management and other related services to patients, oncology practices, and hospitals. These services encompass clinical coordination and review, compliance with appropriate oncology protocols, patient assistance with outside funding, and timely delivery of medication. We coordinate the administration of medications to the physician's office or directly to the patient at the appropriate point of treatment. We work directly with the payers to bill insurance companies for the medication provided, ensuring all prior authorizations and approvals are obtained. These services offer physicians an alternative to the traditional buy-and-bill distribution model, allowing them to outsource drug procurement, inventory management, and prescription administration.

Our Business Focus

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

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

Acquire Competitors. We also intend to expand our market share through selected geographic expansion in markets not currently served by us and through strategic acquisitions in existing and underserved markets. The Corporation currently operates in 45 states. We believe that there are growth opportunities in several other markets. There are

numerous businesses in our markets, mostly small or regional companies that lack the scale that we believe will be necessary to ultimately compete in a market that is national in scope. We intend to actively seek opportunities to acquire companies. Since its formation in 2006, the Corporation has acquired 19 institutional pharmacy businesses, four specialty infusion services businesses, one specialty oncology pharmacy and one hospital services business.

Sales and Marketing

We sell our products and services through a national sales force. The sales force is organized by both geographic lines and size of client. We believe this helps us 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. At December 31, 2015, the Corporation provided institutional pharmacy services to patients in 45 states. Our customers are typically institutional healthcare providers, such as skilled nursing facilities, nursing centers, assisted living facilities and other long-term alternative care settings. We are generally the primary source of pharmaceuticals for our customers.

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

Specialty Infusion Services. At December 31, 2015, the Corporation provided specialty infusion services to patients in 14 states with acute or chronic conditions in a setting outside of a hospital or nursing home.

Specialty Oncology Services. At December 31, 2015, the Corporation provided specialty oncology medication services to patients in 46 states with acute and chronic conditions in a hospital or physician practice or the home setting.

Suppliers/Inventory

We obtain pharmaceutical and other products from Cardinal Health ("Cardinal Health") and other contracts negotiated directly with pharmaceutical manufacturers for discounted prices. The Corporation entered into a Prime Vendor Agreement with Cardinal effective April 1, 2015 ("Cardinal Health PVA"). The initial term of the agreement is through June 30, 2018 and contains one year automatic renewal provisions. The Cardinal Health PVA requires the Corporation to purchase certain levels of brand and non-injectable generic drugs from Cardinal Health. The Cardinal Health PVA does provide flexibility for the Corporation to contract with other suppliers. Under the agreement, the Corporation is entitled to certain rebates based on drug purchases. The loss of a supplier could adversely affect our business if alternate sources of supply are unavailable or if available are significantly more expensive.

We seek to maintain an on-site inventory of pharmaceuticals and supplies to ensure prompt delivery to our customers. Cardinal Health maintains local distribution facilities in most major geographic markets in which we operate. In addition, we supply many of our pharmacies with select products from a distribution center operated by a third-party logistics company.

Brand to Generic Conversions

The following table summarizes the Corporation's generic drug dispensing rate:

2013	2014	2015
83.4%	84.9%	86.0%

The following table summarizes the material brand-to-generic conversions expected to occur in 2016 through 2019:

2016	2017	2018	2019
Gleevec (Q1)*	Azilect(Q1)	Sensipar (Q1)*	Renexa (Q1)*
Combivent (Q2)*	Vytorin (Q2)	Nasonex (Q2)	Lyrica (Q2)*
Crestor (Q2)*	Reyataz (Q4)		Vesicare (Q2)*
Cubicin (Q2)*			
Tamiflu (Q3)			
Kaletra (Q4)			
Norvir (Q4)			
Seroquel XR (Q4)*			
Zetia (Q4)*			

* These represent the most significant brand-to-generic conversions
(Number in parentheses refers to the expected quarter of conversion)

When a branded drug shifts to a generic, initial pricing of the generic drug in the market will vary depending on the number of manufacturers launching their generic version of the drug. Historically, a shift from brand-to-generic decreased our revenue and improved our gross margin from sales of these classes of drugs during the initial time period that a brand drug has a generic alternative. Third-party payers may reduce their reimbursements to the Corporation after the initial period. In addition, the number of generic manufacturers entering the market impacts the

overall cost and reimbursement of generic drugs. This acceleration in the reimbursement reduction and the number of generic manufacturers generally result in margin compression. Due to the unique nature of the brand-to-generic conversion, management cannot estimate the future financial impact of the brand-to-generic conversions on the Corporation's results of operations.

Supplier and Manufacturer Rebates

We currently receive rebates from certain manufacturers and distributors of pharmaceutical products for achieving targets of market share or purchase volumes. Rebates are designed to prefer, protect, or maintain a manufacturer's products that are dispensed by the pharmacy under its formulary. Rebates for brand name products are generally based upon achieving a defined market share tier within a therapeutic class and can be based on either purchasing volumes or actual prescriptions dispensed. Rebates for generic products are more likely to be based on achieving purchasing volume requirements.

Information Technology

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

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

Sources of Pharmacy Revenues

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

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

	2013		2014		2015	
	Amount	% of Revenues	Amount	% of Revenues	Amount	% of Revenues
Medicare Part D	$813.7	46.3 %	$866.0	45.7 %	$951.3	46.9 %
Institutional healthcare providers	519.2	29.5	459.7	24.3	469.8	23.2
Medicaid	157.0	9.0	167.1	8.8	150.1	7.4
Private and other	77.2	4.4	81.9	4.3	79.4	3.9
Insured	113.0	6.4	239.0	12.6	291.0	14.4
Medicare	15.5	0.9	21.9	1.2	22.2	1.1
Hospital management fees	62.3	3.5	58.9	3.1	64.7	3.1
Total	$1,757.9	100.0 %	$1,894.5	100.0 %	$2,028.5	100.0 %

The change in the revenue by payer type, as a percent of total revenue, over the three year period is a result of the 2012 acquisition of Amerita, subsequent infusion acquisitions made by Amerita and the 2013 acquisition of Onco, all of which are more heavily weighted to insured payer sources.

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 larger competitor in the institutional pharmacy industry, Omnicare, Inc., a division of CVS Health (NYSE: CVS).

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

Patents, Trademarks and Licenses

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

We have various proprietary products, processes, software and other intellectual property that are used either to facilitate the conduct of our business or that are made available as products or services to customers. We generally

seek to protect such intellectual property through a combination of trade secret, patent and copyright laws and through confidentiality and other contractually imposed protections.

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

Seasonality

Our largest customers in institutional pharmacy services are skilled nursing facilities. Both prescription and non-prescription drug sales at skilled nursing facilities are affected by the timing and severity of the cold/flu season and other seasonality of the long-term care facilities industry, however seasonality does not have a material effect on the Corporation's consolidated financial results.

Working Capital

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

Employees

As of December 31, 2015, we had approximately 5,800 employees which included approximately 1,200 part-time employees. The Corporation had approximately 300 employees that were covered by collective bargaining agreements as of December 31, 2015. As of December 31, 2015, we employed approximately 1,700 licensed pharmacists. We believe that our relationships with our employees are good.

Government Regulation

General

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

Licensure, Certification and Regulation

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

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

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

Laws Affecting Referrals and Business Practices

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

- the federal "anti-kickback" statute, which prohibits, among other things, knowingly or willfully soliciting, receiving, offering or paying remuneration "including any kickback, bribe or rebate" directly or indirectly in return for or to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other federal healthcare programs; and
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the federal "Stark laws" which prohibit, with limited exceptions, the referral of patients by physicians for certain designated health services, to an entity with which the physician has a financial relationship.

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

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

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 and deceptive trade practices.

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

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

State Laws Affecting Access to Services

Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation. These laws may preclude a nursing center from requiring their patients and residents to purchase pharmacy or other ancillary medical services or supplies from particular providers that have a

supplier relationship with the nursing center. Limitations such as these may increase the competition which we face in providing services to nursing center residents.

HIPAA

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

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

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

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

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

The Health Information Technology for Economic and Clinical Health Act ("HITECH"), part of the American Recovery and Reinvestment Act of 2009, changed several aspects of HIPAA including, without limitation, the following: (i) applies HIPAA security provisions and penalties directly to business associates of covered entities; (ii) requires certain notifications in the event of a security breach involving PHI; (iii) restricts certain unauthorized disclosures; (iv) changes the treatment of certain marketing activities; and (v) strengthens enforcement activities. In addition, the Secretary of the United States Department of Health and Human Services issued an interim final rule on August 24, 2009 that requires notifications for certain unpermitted disclosures of PHI. The final rule was issued on January 17, 2013.

2010 Health Care Reform Legislation

The Patient Protection and Affordable Care Act and the reconciliation law known as Health Care and Education Affordability Reconciliation Act (combined we refer to both Acts as the "2010 Health Care Reform Legislation") were enacted in March 2010. State participation in the expansion of Medicaid under the 2010 Health Care Reform Legislation is voluntary. Three key provisions of the 2010 Health Care Reform Legislation that are relevant to the Corporation are: (i) the gradual modification to the calculation of the Federal Upper Limit ("FUL") for drug prices and the definition of Average Manufacturer's Price ("AMP"), (ii) the closure, over time, of the Medicare Part D coverage gap, which is otherwise known as the "Donut Hole," and (iii) short cycle dispensing. Regulations under the 2010 Health Care Reform Legislation are expected to continue being drafted, released, and finalized throughout the next several years.

FUL and AMP Changes

The reimbursement rates for pharmacy services under Medicaid are determined on a state-by-state basis subject to review by Centers for Medicare and Medicaid Services ("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 the established limits, at rates determined in accordance with each state's regulations. Federal regulations and the regulations of certain states establish "upper limits" for reimbursement of certain prescription drugs under Medicaid (these upper limits being the "FUL").

The 2010 Health Care Reform Legislation amended the Deficit Reduction Act of 2005 (the "DRA") to change the definition of the FUL by requiring the calculation of the FUL as no less than 175% of the weighted average, based on utilization, of the most recently reported monthly AMP for pharmaceutically and therapeutically equivalent

multi-source drugs available through retail community pharmacies nationally.

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

On February 1, 2016, CMS released a Final Rule titled Medicaid Program; Covered Outpatient Drugs. This Final Rule details the types of sales that are to be included and excluded in determining AMP. Moreover, consistent with the 2010 Health Care Reform Legislation, the Final Rule calculates the FULs at 175% of the weighted average, determined based on the basis of utilization, of the most recently reported monthly AMP. As an exception, however, if the AMP-based FUL is lower than the National Average Drug Acquisition Cost ("NADAC"), the FULs will be set at the drug's NADAC. This Final Rule will be effective on April 1, 2016.

CMS has stated that it plans to publish the draft FULs in accordance with the Final Rule for two months before finalizing the FULs. The final FULs will be published in late March 2016 and will be effective April 1, 2016 to coincide with the effective date of the Final Rule. States will have 30 days following this effective date to implement the FULs. CMS will update the FULs on a monthly basis thereafter, which will become effective on the first date of the month following their publication. Again, states will then have 30 days after the effective date of the monthly updates to implement the new FULs.

The Final Rule also changed how states reimburse pharmacies. The Final Rule now requires states to pay pharmacies based on the actual acquisition cost of the drug, as opposed to the estimated acquisition cost. Moreover, the Final Rule requires states to consider the sufficiency of both the ingredient cost reimbursement and dispensing fee reimbursement when proposing changes to either of these components of reimbursement for Medicaid covered drugs.

CMS will continue to post draft monthly FULs. The Corporation will continue to analyze the effect of these changes on its business, results of operations, and liquidity.

Short Cycle Dispensing and Dispensing Fees

Pursuant to the 2010 Health Care Reform Legislation, Prescription Drug Plans ("PDPs") are required, under Medicare Part D and Medicare Advantage prescription drug plans ("Medicare Advantage" or "MAPDs") to utilize specific, uniform dispensing techniques, such as weekly, daily, or automated dose dispensing, when dispensing covered Medicare Part D drugs to beneficiaries who reside in a long-term care facility to reduce waste associated with 30 to 90 day prescriptions for such beneficiaries. Pursuant to CMS issued regulation, beginning January 1, 2013, pharmacies dispensing to long-term care facilities must dispense no more than 14-day supplies of brand-name oral solid medications covered by Medicare Part D. The Corporation fully implemented short cycle dispensing on January 1, 2013. The impact of short cycle dispensing has not had a material adverse impact on the Corporation's results of operations.

Medicare Part D Changes

In a February 12, 2015 Final Rule entitled "Medicare Program: Contract Year 2016 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs", CMS finalized a regulation, effective January 1, 2016, prohibiting financial arrangements that penalize more efficient long-term care dispensing techniques (e.g., dispensing a 3 day supply over a 14 day supply) through pro-rated dispensing fees based on a day's supply or quantity dispensed. CMS also finalized a requirement that, effective January 1, 2016, any differences in payment methodologies among long-term care pharmacies incentivize more efficient dispensing techniques. The Corporation is unable to evaluate the full impact of these changes on its business at this time.

CIA and DEA MOA

In May 2015, the Corporation entered into a five-year Corporate Integrity Agreement ("CIA") with United States Department of Health and Human Services Office of the Inspector General ("OIG") and a Memorandum of Agreement ("MOA") with the Drug Enforcement Agency ("DEA") concurrent with the execution of settlement agreements with the OIG and the DEA settling alleged Controlled Substance Act ("CSA") violations and associated

False Claims Act allegations.

The CIA requires the Corporation, among other things to : (i) create procedures designed to ensure it complies with the CSA and related regulations, (ii) retain an independent review organization to review the Corporation's compliance with the terms of the CIA and report to the OIG regarding that compliance; and (iii) provide training for certain Corporation employees as to the Corporation's requirements under the CSA. If the Corporation fails to comply with the terms of the CIA, it may be required to pay certain monetary penalties. Furthermore, if the Corporation commits a material breach of the CIA, the OIG may exclude the Corporation from participating in federal healthcare programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and potentially have a material adverse effect on our financial condition, results of operations and business prospects.

The MOA requires the Corporation to comply with all requirements of the CSA, specifically relating to the dispensing of scheduled prescription drugs. If the Corporation fails to comply with the terms of the MOA, the DEA may suspend a Corporation's pharmacy DEA Certificate of Registration and begin an administrative hearing process pursuant to 21 U.S.C. Section 824. Any such suspension would prohibit the Corporation's pharmacy from dispensing scheduled prescription drugs and would lead to the revocation or termination of contracts and/or licenses and potentially have a materially adverse effect on our financial condition, results of operations and business prospects.

Overview of Reimbursement

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

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

Medicare

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

Part A

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

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

Part D

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

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

We obtain reimbursement for drugs we provide to enrollees of the given Part D Plan in accordance with the terms of agreements negotiated between us and the Part D Plan. The Medicare Part D final rule prohibits Part D plans from paying for drugs and services not specifically called for by the BBA.

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

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

Medicaid

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

Environmental Matters

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

Available Information

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

Public Reference Room is available by calling the SEC at 1-800-SEC-0330. Information that we file with the SEC is also available at the SEC's web site at www.sec.gov.

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

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

Item 1A. Risk Factors

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

Risk Factors Relating to Our Business

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

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

Intense competition may erode our profit margins.

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

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

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

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

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

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

regulations relating to any of these programs may materially adversely affect our business.

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

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

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

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

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

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

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

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

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

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

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

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

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

Pharmaceutical products can develop unexpected safety or efficacy concerns.

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

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

Both our own profit margins and the profit margins of our customers may be adversely affected by laws and regulations reducing reimbursement rates and charges. The sources and amounts of our revenues are determined by a number of factors, including licensed bed capacity and occupancy rates of our customers, the number of drugs

administered to patients, the mix of pharmaceuticals dispensed, whether the drugs are brand or generic, and the rates of reimbursement among payers. Changes in the number of drugs administered to patients, as well as payer mix among private pay, Medicare and Medicaid, in our customers' facilities will significantly affect our earnings and cash flow.

Further modifications to the Medicare Part D program may reduce revenue and impose additional costs to the industry.

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

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

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

Changes in Medicaid reimbursement may reduce our revenue.

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

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

On February 1, 2016, CMS released a Final Rule titled Medicaid Program; Covered Outpatient Drugs. This Final Rule details the types of sales that are to be included and excluded in determining AMP. Moreover, consistent with the 2010 Health Care Reform Legislation, the Final Rule calculates the FULs at 175% of the weighted average, determined based on the basis of utilization, of the most recently reported monthly AMP. As an exception, however, if the AMP-based FUL is lower than the National Average Drug Acquisition Cost ("NADAC"), the FULs will be set at the drug's NADAC. This Final Rule will be effective on April 1, 2016.

CMS has stated that it plans to publish the draft FULs in accordance with the Final Rule for two months before finalizing the FULs. The final FULs will be published in late March 2016 and will be effective April 1, 2016 to coincide with the effective date of the Final Rule. States will have 30 days following this effective date to implement the FULs. CMS will update the FULs on a monthly basis thereafter, which will become effective on the first date of the month following their publication. Again, states will then have 30 days after the effective date of the monthly updates to implement the new FULs.

The Final Rule also changed how states reimburse pharmacies. The Final Rule now requires states to pay pharmacies based on the actual acquisition cost of the drug, as opposed to the estimated acquisition cost. Moreover, the Final Rule requires states to consider the sufficiency of both the ingredient cost reimbursement and dispensing fee reimbursement when proposing changes to either of these components of reimbursement for Medicaid covered drugs.

CMS will continue to post draft monthly FULs. The Corporation will continue to analyze the effect of these changes on its business, 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 healthcare industry is subject to substantial federal and state government regulation and audit. Legal actions could result in substantial monetary damages as well as damage to the Corporation's reputation with customers, which could have a material adverse effect upon our financial condition, results of operations, and liquidity.

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

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

Among these laws is the federal anti-kickback statute. This statute prohibits anyone from knowingly and willfully soliciting, receiving, offering or paying any remuneration with the intent to refer, or to arrange for the referral or order of, services or items payable under a federal healthcare program. Courts have interpreted this statute broadly. Violations of the anti-kickback statute may be punished by a criminal fine of up to $25,000 for each violation or

imprisonment, civil money penalties of up to $50,000 per violation and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal healthcare programs, including Medicare and Medicaid. This law impacts the relationships that we may have with potential referral sources. We have a variety of relationships with potential referral sources, including hospitals and skilled nursing facilities with which we have contracted to provide pharmacy services. The OIG, among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse or waste. The OIG carries out this responsibility through a nationwide program of audits, investigations and inspections. The OIG has promulgated safe harbor regulations that outline practices that are deemed protected from prosecution under the anti-kickback statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements may not qualify for safe harbor protection. Failure to meet a safe harbor does not mean that the arrangement necessarily violates the anti-kickback statute, but may subject the arrangement to greater scrutiny. It cannot be assured that practices outside of a safe harbor will not be found to violate the anti-kickback statute.

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

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

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

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

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

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

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

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

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

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

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

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

Our pharmacies must be licensed by the state board of pharmacy in the state in which they operate. Many states also regulate out-of-state pharmacies that are delivering prescription products to patients or residents in their states. The failure to obtain or renew any required regulatory approvals or licenses could adversely impact the operation of our business. In addition, the healthcare facilities we service are also subject to extensive federal, state and local regulations and are required to be licensed in the states in which they are located. The failure by these healthcare

facilities to comply with these or future regulations or to obtain or renew any required licenses could result in our inability to provide pharmacy services to these facilities and their residents and could have a material adverse effect on our financial condition, results of operations and liquidity.

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

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

We must comply with extensive federal and state requirements regarding the transmission and retention of health information. The Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, referred to as HIPAA, was enacted to ensure that employees can retain and at times transfer their health insurance when they change jobs, to enhance the privacy and security of personal health information and to simplify healthcare administrative processes. HIPAA requires the adoption of standards for the exchange of electronic health information.

The HITECH, part of the American Recovery and Reinvestment Act of 2009, changed several aspects of HIPAA including, without limitation, the following: (i) applies HIPAA security provisions and penalties directly to business associates of covered entities; (ii) requires certain notifications in the event of a security breach involving PHI; (iii) restricts certain unauthorized disclosures; (iv) changes the treatment of certain marketing activities; and (v) strengthens enforcement activities. In addition, the Secretary of Health and Human Services issued an interim final rule on August 24, 2009 that requires notifications for certain unpermitted disclosures of PHI. The final rule was issued on January 17, 2013.

Failure to comply with either HIPAA or HITECH could result in fines and penalties that could have a material adverse effect on our results of operations, financial condition, and liquidity.

If we fail to comply with the terms of our Corporate Integrity Agreement with the OIG or Memorandum of Agreement with the DEA, it could subject us to substantial monetary penalties or suspension or termination from participation in federal healthcare programs.

In May 2015, the Corporation entered into a five-year CIA with the OIG and a MOA with the DEA concurrent with the execution of settlement agreements with the OIG and the DEA settling alleged CSA violations and associated False Claims Act allegations.

The CIA requires the Corporation, among other things to: (i) create procedures designed to ensure it complies with the CSA and related regulations; (ii) retain an independent review organization to review the Corporation's compliance with the terms of the CIA and report to the OIG regarding that compliance; and (iii) provide training for certain Corporation employees and the Board of Directors as to the Corporation's requirements under the CSA. If the Corporation fails to comply with the terms of the CIA, it may be required to pay certain monetary penalties. The imposition of monetary penalties would adversely affect our profitability. Furthermore, if the Corporation commits a material breach of the CIA, the OIG may exclude the Corporation from participating in federal healthcare programs. Any such exclusion would result in the revocation or termination of contracts and/or licenses and potentially have a material adverse effect on our financial condition, results of operations and business prospects.

The MOA requires the Corporation to comply with all requirements of the CSA, specifically relating to the dispensing of scheduled prescription drugs. If the Corporation fails to comply with the terms of the MOA, the DEA may suspend a Corporation's pharmacy DEA Certificate of Registration and begin an administrative hearing process pursuant to 21 U.S.C. Section 824. Any such suspension would prohibit the Corporation's pharmacy from dispensing scheduled prescription drugs and would lead to the revocation or termination of contracts and/or licenses and potentially have a materially adverse effect on our financial condition, results of operation and business prospects.

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

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

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

- difficulties integrating acquired operations, personnel and information systems, or in realizing projected efficiencies and cost savings;
- diversion of management's time from existing operations;

- potential loss of key employees or customers of acquired companies;
- inaccurate assessment of assets and liabilities and exposure to undisclosed or unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare laws;
- increases in our indebtedness and a limitation on our ability to access additional capital when needed; and
- failure to operate acquired facilities profitably or to achieve improvements in their financial performance.

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

We rely on sophisticated information systems in our business to obtain, rapidly process, analyze, and manage data to facilitate the dispensing of prescription and non-prescription pharmaceuticals in accordance with physician orders and deliver those medications to patients and long-term care residents on a timely basis; to manage the accurate billing and collections for thousands of customers; and to process payments to suppliers. Our business and results of operations may be materially adversely affected if these systems are interrupted for any reason, including cyber security threats, or damaged or if they fail for an extended period of time. Significant disruptions to our infrastructure or any of our facilities due to failure of technology or some other catastrophic event could adversely impact our business.

Cybersecurity attacks or other data security incidents could disrupt our operations and expose us to regulatory fines or penalties, liability or reputational damage.

In the ordinary course of our business, we process, store and transmit data, which may include sensitive personal information as well as proprietary or confidential information relating to our business or third parties. Although we have information technology security systems, a successful cybersecurity attack or other data security incident could result in the misappropriation of confidential or personal information, create system interruptions, or deploy malicious software that attacks our systems. Such an attack or incident could result in business interruptions from the disruption of our information technology systems or negative publicity resulting in reputational damage with our customers, shareholders and other stakeholders. In addition, the unauthorized dissemination of sensitive personal information or proprietary or confidential information could expose us or other third-parties to regulatory fines or penalties, litigation and potential liability, or otherwise harm our business.

We purchase a significant portion of our pharmaceutical products from one supplier and receive a significant amount of rebates from the same supplier.

Effective April 1, 2015, we entered into a new Prime Vendor Agreement to purchase our pharmaceutical products from Cardinal Health. If Cardinal Health fails to deliver products in accordance with the agreement, there can be no assurance that our operations would not be disrupted or that we could obtain the products at similar cost or at all. In this event, failure to satisfy our customers' requirements would result in defaults under these customer contracts subjecting us to damages and the potential termination of those contracts. Such events could have a material adverse effect on our financial condition, results of operations and liquidity.

The Cardinal Health PVA requires the Corporation to purchase certain levels of brand and non-injectable generic drugs from Cardinal Health. The Cardinal Health PVA does provide flexibility for the Corporation to contract with other suppliers. Under the agreement, the Corporation is entitled to certain rebates based on drug purchases.

A loss in rebates and other pricing terms under the Previous PVA may adversely impact our financial results.

The Corporation previously had a Prime Vendor Agreement (the "Previous PVA") with AmerisourceBergen Drug Corporation ("ABDC"). As a result of ABDC's failure to comply with certain pricing and rebate provisions of the Previous PVA, the Corporation had recorded a receivable of $40.8 million related to these disputes at December 31,2014. Separately, as of December 31, 2014, the Corporation had recorded $12.2 million for additional rebates owing from ABDC which at that time the Corporation believed were not in dispute and had previously been paid by ABDC in all the prior quarters. All these receivables totaled $53.0 million and were included in prepaids and other assets in the accompanying consolidated balance sheet as of December 31, 2014. During the period of January 1, 2015 through December 31, 2015, an additional $19.3 million, net of payments received, of certain rebates and guarantees owed by ABDC under the Previous PVA were recognized which brought the total gross receivable to $72.3 million and which is included in other long-term assets in the accompanying consolidated balance sheet as of December 31, 2015; these amounts are currently in dispute and are the subject of litigation between the parties. At this time, the Corporation is unable to determine the ultimate impact of these litigation proceedings on its consolidated financial condition, results of operations, or liquidity.

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

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

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

We have $371.0 million of goodwill and $190.2 million of recorded intangible assets on our consolidated balance sheet as of December 31, 2015. Our intangible assets primarily represent the value of client relationships that were recorded from past acquisitions. Under current accounting rules, intangible assets are amortized over their useful lives. These assets may become impaired with the loss of significant clients. If the carrying amount of the assets exceeds the undiscounted pre-tax expected future cash flows from the lowest appropriate asset grouping, we would be required to record a non-cash impairment charge to our consolidated income statements in the amount the carrying value of these assets exceeds its fair value. In addition, while the intangible assets may not be impaired, the useful lives are subject to continual assessment, taking into account historical and expected losses of relationships that were in the base at time of acquisition. This assessment may result in a reduction of the remaining weighted average useful life of these assets, resulting in potentially significant increases to non-cash amortization expense that is charged to our consolidated income statements. A goodwill or intangible asset impairment charge, or a reduction of useful lives, could have a material effect on our results of operations.

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

We are highly dependent upon the members of our senior management and our pharmacists and other pharmacy professionals. Our business is managed by a small number of senior management personnel. If we were unable to retain these persons, we might be materially adversely affected due to the limited pool of senior management personnel with significant experience in our industry. Accordingly, we believe we could experience significant difficulty in replacing key management personnel. We expect that any employment contracts we enter into with our key management personnel will be subject to termination without cause by either party. Moreover, although the

majority of the members of our senior management team have significant experience in the industry, they will need time to fully assess and understand our business and operations. We can offer no assurance how long these members of senior management will choose to remain with us.

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

Our revenues and volume trends may be adversely affected by certain factors relevant to the markets in which we have pharmacies, including weather conditions and other natural disasters, some of which may not be covered by insurance.

Our revenues and volume trends will be predicated on many factors, including physicians' pharmaceutical decisions on patients, payer programs, seasonal and severe weather conditions including the effects of extreme low temperatures, hurricanes and tornadoes, earthquakes, current local economic and demographic changes, some of which may not be covered by insurance. Any of these factors could have a material adverse effect on our revenues and volume trends, and many of these factors will not be within the control of our management. These factors may also have an effect on our customers and their ability to continue to operate. For further discussion, see Note 9.

There are inherent uncertainties involved in estimates, judgments, and assumptions used in the determination of our litigation-related accruals and the preparation of financial statements in accordance with generally accepted accounting principles in the United States (U.S. GAAP). Any changes in estimates, judgments, and assumptions could have a material adverse effect on the Corporation's financial position, results of operations, or cash flows.

Our financial statements filed with the SEC are prepared in accordance with U.S. GAAP, and the preparation of such financial statements includes making estimates, judgments, and assumptions that affect reported amounts of assets, liabilities, and related reserves, revenues, expenses, and income. We evaluate our exposure to legal proceedings and establish reserves for the estimated liabilities in accordance with U.S. GAAP. Assessing and predicting the outcome of these matters involves substantial uncertainties. Unexpected outcomes in these legal proceedings, or changes in management's evaluations or predictions and accompanying changes in established reserves, could have a material adverse impact on our financial results. Estimates are inherently subject to change in the future, and such changes could result in corresponding changes to the amounts of assets, liabilities, income, or expenses and likewise could have an adverse effect on our financial position, results of operations, or cash flows.

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

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

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

- prohibit stockholder action except at an annual or special meeting. Specifically, this means our stockholders are unable to act by written consent;
- regulate how stockholders may present proposals or nominate directors for election at annual meetings of stockholders. Advance notice of such proposals or nominations is required;
- regulate how special meetings of stockholders may be called. Our stockholders do not have the right to call special meetings;
- authorize our board of directors to issue preferred stock in one or more series, without stockholder approval. Under this authority, our Board of Directors adopted the Rights Agreement which could ensure continuity of management by rendering it more difficult for a potential acquirer to obtain control of us; and
- require an affirmative vote of the holders of three-quarters or more of the combined voting power of our common stock entitled to vote in the election of our directors in order for the stockholders to amend our bylaws.

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

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

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

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

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

Acquisitions, investments and strategic alliances we may make in the future may need to be financed by borrowings under the Credit Agreement for which funds may not be made available by certain participants.

We have made and anticipate that we may continue to make acquisitions of, investments in and strategic alliances with complementary businesses to enable us to capitalize on our position in the geographic markets in which we

operate and to expand our business in new geographic markets. Our growth plans rely, in part, on the successful completion of future acquisitions. At any particular time, we may need to finance such acquisitions and strategic alliances with borrowings under the Credit Agreement. The financial markets are very volatile and certain participants in our Credit Agreement 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 adversely impacted.

We are exposed to interest rate changes.

We are exposed to market risk related to changes in interest rates. As of December 31, 2015, we had outstanding debt of $426.4 million outstanding under our Credit Agreement and revolver, all of which was subject to variable rates of interest. See Item 7A, "Quantitative and Qualitative Disclosures about Market Risk."

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

We have $426.4 million in indebtedness outstanding as of December 31, 2015 under our Credit Agreement and revolver. We also have $0.9 million in capital lease obligations at December 31, 2015.

On September 17, 2014, the Corporation entered into a $535.0 million Credit Agreement by and among the Corporation, the lenders named therein, Bank of America, N.A., as administrative agent, JP Morgan Chase Bank N.A., as syndication agent, and U.S. Bank, National Association, Citibank, N.A., MUFG Union Bank, N.A., BBVA Compass Bank and SunTrust Bank as co-documentation agents (the "Credit Agreement"). The Credit Agreement replaced the $450.0 million five-year credit agreement dated as of May 2, 2011, among the Corporation, Citibank, N.A., as Administrative Agent, and certain lenders. The Credit Agreement consists of a $225.0 million term loan facility and a $310.0 million revolving credit facility. The terms and conditions of the Credit Agreement are customary to facilities of this nature. Unless terminated earlier, the Credit Agreement will mature on September 17, 2019, and the principal amount outstanding thereunder, together with all accrued unpaid interest and other amounts owed thereunder, if any, will be payable in full on such date. The Credit Agreement also contains financial covenants that require us to satisfy certain financial tests and maintain certain financial ratios. The Credit Agreement limits our ability to declare and pay dividends or other distributions on our shares of common stock. If our lenders permit us to declare dividends, the dividend amounts, if any, will be determined by our Board of Directors, which will consider a number of factors, including our financial condition, capital requirements, funds generated from operations, future business prospects, applicable contractual restrictions and any other factors our Board of Directors may deem relevant. The amount of this outstanding indebtedness could limit our ability to pay cash dividends and to obtain additional financing in the future for working capital, capital expenditure and acquisition purposes. A significant portion of our cash flows will be dedicated to debt service and will be unavailable for investment, capital expenditures or other operating expenses.

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

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

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

Item 1B. Unresolved Staff Comments

We received a comment letter from the Securities and Exchange Commission ("SEC") Division of Corporate Finance, dated November 24, 2015 with respect to our Annual Report on Form 10-K for the year ended December 31, 2014 and our Quarterly Report on Form 10-Q for the quarter ended September 30, 2015. We submitted a response to that initial comment letter and have received follow-up comments and submitted responses to the follow-up comments as well. As of the date of this Report, we believe that the only comments that remain open relate to our accounting for the $71.5 million receivable from ABDC as of September 30, 2015 and the withholding of approximately $48.8 million of normal recurring payments due to ABDC. We will continue to cooperate with the SEC to resolve these remaining comments. Although we do not currently believe it to be necessary, it is possible that the ultimate resolution of these remaining comments could result in an adjustment to our accounting treatment of such amounts, which may affect the presentation of our financial statements.

Item 2. Properties

We have facilities including offices and key operating facilities in various locations throughout the United States. The Corporation's corporate headquarters are located in Louisville, Kentucky. In addition to the pharmacies listed below, the Corporation also has multiple facilities throughout the nation with several overhead and administrative functions. As of December 31, 2015, all facilities were leased. We consider all of these facilities to be suitable and adequate.

The following table presents certain information with respect to operating leases of our pharmacies identified by the Corporation as properties as of December 31, 2015:

Property	# of Facilities	Square Footage	Property	# of Facilities	Square Footage
Alabama	2	20,330	Mississippi	1	11,600
Arizona	4	28,536	Missouri	1	4,090
Arkansas	2	8,850	Montana	1	2,440
California	10	88,427	Nebraska	1	5,120
Colorado	4	32,054	Nevada	2	9,373
Connecticut	1	12,600	New Hampshire	1	7,500
Delaware	1	5,739	New Jersey	2	14,310
Florida	6	61,101	New Mexico	1	4,798
Georgia	2	33,202	New York	5	91,331
Hawaii	5	15,506	North Carolina	3	21,250
Idaho	1	4,031	Ohio	2	28,050
Illinois	1	15,495	Oklahoma	2	12,786
Indiana	1	20,386	Pennsylvania	8	52,545
Iowa	1	6,250	Rhode Island	1	9,415
Kansas	2	10,494	South Carolina	2	20,350
Kentucky	3	29,924	South Dakota	2	11,050
Louisiana	1	4,914	Tennessee	5	47,919
Maine	1	10,200	Texas	13	93,189
Maryland	1	8,584	Utah	2	15,002
Massachusetts	2	33,722	Virginia	2	15,807
Michigan	3	56,720	Washington	2	12,973
Minnesota	1	6,727	West Virginia	1	8,900
			Wisconsin	1	3,750

Item 3. Legal Proceedings

On March 4, 2011, a relator, Mark Silver, on behalf of the U.S. Government and various state governments, filed a complaint in the United States District Court for the District of New Jersey against the Corporation alleging that the Corporation violated the Federal False Claims Act ("FCA") and Federal Anti-Kickback Statute through its agreements to provide prescription drugs to nursing homes under certain Medicare and Medicaid programs. On February 19, 2013, the U.S. Government declined to intervene in the case. The complaint has been amended several times, most recently on November 12, 2013, and thereafter served upon the Corporation. On December 6, 2013, the Corporation moved to dismiss the amended complaint for failure to state a claim upon which relief may be granted and on September 29, 2014, the court declined to dismiss the case, but limited the relevant time period for which claims could be brought against the Corporation. On December 22, 2015, Silver and the Corporation filed a joint motion with the court for an order dismissing with prejudice all successor liability claims against the Corporation for or regarding the conduct of Chem Rx Corporation. The court has not yet ruled on the motion or entered the order of dismissal. The

Corporation intends to vigorously defend itself against these allegations.

On November 20, 2013, a complaint filed by a relator, Robert Gadbois, on behalf of the U.S. Government and various state governments, was unsealed by the United States District Court for the District of Rhode Island against the Corporation alleging that the Corporation dispensed controlled and non-controlled substances in violation of the CSA and that, as a result, the dispenses were not eligible for payment and that the claims the Corporation submitted to the Government were false within the meaning of the FCA. The U.S. Government and the various state governments declined to intervene in this case. On October 3, 2014, the Corporation's motion to dismiss was granted by the court. The relator appealed the court's decision and on December 16, 2015, the First Circuit Court of Appeals granted the relator its appeal and remanded the case to the District Court to allow the relator to file a motion to supplement his complaint and to allow the District Court to rule upon that motion. On December 30, 2015, the Corporation filed with the First Circuit Court of Appeals a petition for a re-hearing en banc, which was denied on January 25, 2016. The Corporation plans to file a petition with the U.S. Supreme Court for a writ of certiorari asking the Supreme Court to review the First Circuit's decision. The Corporation otherwise intends to continue to defend the case vigorously.

On October 29, 2013, a complaint was filed in the United States District Court for the Southern District of Florida by Pines Nursing Homes (77), Inc. as a putative class action against the Corporation. The complaint alleged that the Corporation sent unsolicited advertisements promoting the Corporation's goods or services by facsimile to individuals or entities, and that such communications did not include an opt-out clause, all in violation of the federal Telephone Consumer Protection Act ("TCPA"). The Complaint did not specify the amount of damages sought, but the TCPA provides a statutory remedy of $500 per facsimile communication sent in violation of the statute, which may be trebled in the event of a willful violation. On August 18, 2014, the Corporation entered into a Settlement Agreement with the putative class and class counsel resolving all claims raised in the complaint. The parties moved on September 8, 2014 for, among other things, certification of the putative class for the purposes of effectuating the settlement and preliminary approval of the parties' settlement. On June 26, 2015, the Court granted preliminary approval of the settlement and the Court approved the settlement on November 12, 2015. The matter is concluded.
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On January 31, 2014, a relator, Frank Kurnik, on behalf of the U.S. Government and various state governments served its complaint filed in the United States District Court for the District of South Carolina alleging that the Corporation solicited and received remuneration in violation of the Federal Anti-Kickback Statute from drug manufacturer Amgen in exchange for preferring and promoting Amgen's drug Aranesp over a competing drug called Procrit. The Complaint was served on the Corporation on January 31, 2014 and subsequently amended on April 24, 2014. The U.S. Government has declined to intervene in the case. The Corporation's motion to dismiss the case was denied by the Court on July 24, 2014. On January 13, 2015, the Corporation again moved to dismiss the complaint and on March 23, 2015, the second motion was denied. On April 2, 2015, the Corporation moved the court to reconsider its denial of the second motion to dismiss and that motion was denied. On December 2, 2015, the Corporation and the Department of Justice settled this matter for $2.5 million plus the relator's attorney fees of approximately $2.0 million which was previously accrued for in the consolidated balance sheets of the Corporation.

The U.S. Department of Justice, through the U.S. Attorney's Office for the Western District of Virginia, investigated whether the Corporation's activities in connection with the agreements it had with the manufacturer of the pharmaceutical Depakote violated the False Claims Act or the Anti-Kickback Statute. The Corporation cooperated with this investigation and believes it has complied with applicable laws and regulations with respect to this matter. On May 29, 2014, the United States District Court for the Western District of Virginia entered an order unsealing two previously partially sealed qui tam complaints, entitled United States, et al., ex rel. Spetter v. Abbott Laboratories. Inc., Omnicare, Inc., and PharMerica Corp., No. l:07-cv-00006 and United States, et al., ex rel. McCoyd v. Abbott Laboratories, Omnicare, Inc., PharMerica Corp., and Miles White, No. l:07-cv-0008. The Corporation entered into a settlement agreement on October 6, 2015 with the Government including the Department of Justice, with approvals from the National Association of Medicaid Fraud Control and the Department of Health and Human Services Office of Inspector General. In the settlement, the Corporation agreed to pay $9.2 million to resolve the matter which was previously accrued for in the consolidated balance sheets of the Corporation.

On September 10, 2014, the Corporation filed a Complaint in Jefferson Circuit Court in Louisville, Kentucky against ABDC for failure of ABDC to comply with certain pricing and rebate provisions of the Previous PVA. The Corporation subsequently filed a First Amended Verified Complaint on September 26, 2014 asserting additional breaches of the Previous PVA.
As a result of ABDC's failure to comply with certain pricing and rebate provisions, the Corporation had recorded a receivable of $40.8 million related to these disputes at December 31, 2014. Separately, as of December 31, 2014, the Corporation had recorded $12.2 million for additional rebates owing from ABDC which at that time the Corporation believed were not in dispute and had previously been paid by ABDC in all the prior quarters. These receivables totaled $53.0 million and were included in prepaids and other assets in the accompanying consolidated balance sheet as of December 31, 2014. During the period of January 1, 2015 through December 31, 2015, an additional $19.3 million, net of payments received, of certain rebates and guarantees owed by ABDC under the Previous PVA were recognized, which brought the total gross receivable to $72.3 million at December 31, 2015.

On March, 2, 2015, the Corporation notified ABDC of its intent to terminate the Previous PVA effective April 1, 2015. The Corporation also announced that it had entered into a Cardinal Health PVA effective April 1, 2015. On March 3, 2015, the Corporation received a letter from ABDC terminating the Previous PVA effective immediately based upon the Corporation's alleged failure to pay certain disputed miscellaneous charges and the Corporation's signing of the Cardinal Health PVA. The Corporation believes ABDC did not have the right to immediately terminate the contract pursuant to the terms of the Previous PVA. On March 6 and March 13, 2015, the Corporation withheld from ABDC normal recurring payments for drug purchases of approximately $48.8 million. On May 18, 2015, ABDC filed an Amended Counterclaim seeking additional financial damages against the Corporation and asserted claims against two counter-defendants. On November 23, 2015, the Corporation filed its Third Amended Complaint against ABDC for additional financial damages, amounts overcharged by ABDC, and for certain rebates not paid by ABDC under the Previous PVA.

All receivables, whether previously disputed or not, due and owing from ABDC at December 31, 2015 and the related amounts allegedly payable to ABDC of $48.8 million, were offset resulting in a net receivable at December 31, 2015 of $23.5 million. This net receivable is included in other assets in the accompanying consolidated balance sheets as of December 31, 2015.

The Corporation has claims for additional damages resulting from ABDC's breaches of the Previous PVA. The Corporation intends to vigorously pursue its claims. At this time, the Corporation is unable to determine the ultimate impact of these litigation proceedings on its consolidated financial condition, results of operations, or liquidity. The litigation with ABDC could continue for an extended period of time, likely longer than 12 months. The Corporation cannot provide any assurances about the outcome of the litigation.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

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

Market Information

Our only class of common equity is our $0.01 par value common stock, which trades on the NYSE under the symbol "PMC".

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

	High	Low	Close
Fiscal 2014			
First Quarter	$28.35	$20.01	$27.98
Second Quarter	$30.48	$25.56	$28.59
Third Quarter	$29.73	$24.12	$24.43
Fourth Quarter	$30.00	$19.42	$20.71
Fiscal 2015			
First Quarter	$28.32	$27.98	$28.19
Second Quarter	$33.87	$33.24	$33.30
Third Quarter	$28.71	$27.57	$28.47
Fourth Quarter	$35.47	$34.46	$35.00

Stockholders

As of February 19, 2016, we had approximately 2400 stockholders of record of the Corporation's common stock. Because many of our shares of common stock are held by brokers and other institutions on behalf of stockholders, we are unable to estimate the total number of stockholders represented by these record holders.

Cash Dividends

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

Securities authorized for issuance under equity compensation plans

Effective April 29, 2015, the Corporation adopted the PharMerica Corporation 2015 Omnibus Incentive Plan (the "Omnibus Plan") under which the Corporation is authorized to grant equity-based and other awards to its employees, officers, directors, and consultants. The Omnibus Plan replaced the Amended and Restated PharMerica Corporation 2007 Omnibus Incentive Plan (the "Prior Plan").

The Corporation has reserved 2,000,000 shares of its common stock for awards to be granted under the Omnibus Plan, subject to certain increases and reductions for grants under the Prior Plan. The following shares shall be added back to the number of shares available for grant under the Omnibus Plan: (i) shares covered by an award that expire or are forfeited, canceled, surrendered, or otherwise terminated without the issuance of such shares; (ii) shares covered by an

award that are settled only in cash; and (iii) shares withheld by the Corporation or any subsidiary to satisfy a tax withholding obligation with respect to full value awards granted pursuant to the Omnibus Plan. However, shares surrendered for the payment of the exercise price under stock options (or options outstanding under the Prior Plan), shares repurchased by us with option proceeds (or option proceeds under the Prior Plan), and shares withheld for taxes upon exercise or vesting of an award other than a full value award (or an award other than a full value award under the Prior Plan), will not again be available for issuance under the Omnibus Plan. In addition, if a stock appreciation right ("SAR") (or SAR under the Prior Plan) is exercised and settled in shares, all of the shares underlying the SAR will be counted against the Omnibus Plan limit regardless of the number of shares used to settle the SAR. The Omnibus Plan provides for certain limits on issuances of certain types of awards and awards to certain recipients. The Omnibus Plan prohibits share recycling for stock options and stock appreciation rights, meaning that shares used to pay the exercise price or tax withholding for those awards are not added back to the share reserve.

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 share and restricted stock units, deferred shares, performance awards, including cash bonus awards, and other stock-based awards. The Corporation's Compensation Committee may condition the vesting, exercise or settlement of any award upon the achievement of one or more performance objectives.

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 units granted to officers generally vest in three equal annual installments. The restricted stock units granted to members of the Board of Directors vest in one annual installment. The performance share units granted under the Omnibus Plan vest based upon the achievement of a target amount of the Corporation's adjusted earnings before interest, income taxes, depreciation and amortization, which reinforces the importance of achieving the Corporation's profitability objectives. The performance is generally measured over a three-year period.

The following table sets forth equity compensation plan information as of December 31, 2015:

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)		Weighted-average exercise price of outstanding options, warrants and rights (b)		Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by stockholders	1,539,607	(1)	$ 14.34	(2)	1,817,038

(1) Includes the following:

- 638,741 shares of common stock to be issued upon exercise of outstanding stock options granted under the Omnibus Plan;
- 456,784 shares of common stock to be issued upon vesting of performance share units under the Omnibus Plan;
- 7,831 shares of common stock to be issued upon vesting of restricted stock awards under the Omnibus Plan; and
- 436,251 shares of common stock to be issued upon vesting of restricted stock units under the Omnibus Plan.

(2) The weighted average exercise price in column (b) does not take into account the 900,866 shares of common stock potentially to be issued under restricted stock awards, performance share units and restricted stock units.

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

Stock Performance Graph

The following graph compares the cumulative total return on a $100 investment in each of the Common Stock of the Corporation, the Standard & Poor's 500 Stock Index and the Standard & Poor's Healthcare Index for the period from December 31, 2010 to December 31, 2015. This graph assumes an investment in the Corporation's common stock and the indices of $100 on December 31, 2010 and that all dividends were reinvested:

	PharMerica Corporation	S&P 500	S&P Healthcare
December 31, 2010	100.00	100.00	100.00
March 31, 2011	99.91	105.42	104.99
June 30, 2011	111.44	105.01	112.65
September 30, 2011	124.63	89.96	100.81
December 31, 2011	132.58	100.00	110.18
March 31, 2012	108.56	111.99	119.46
June 30, 2012	95.37	108.31	120.83
September 30, 2012	110.57	114.55	127.55
December 31, 2012	124.37	113.40	126.91
March 31, 2013	122.27	124.77	146.23
June 30, 2013	121.05	127.72	151.10
September 30, 2013	115.90	133.71	160.65
December 31, 2013	187.77	146.97	176.08
March 31, 2014	244.37	148.88	185.59
June 30, 2014	249.69	155.87	193.14
September 30, 2014	213.36	156.82	202.85
December 31, 2014	180.87	163.71	217.11
March 31, 2015	246.20	164.43	230.48
June 30, 2015	290.83	164.05	236.08
September 30, 2015	248.65	152.67	210.01
December 31, 2015	305.68	162.52	234.23

Recent Sales of Unregistered Securities

None.

Purchases of Equity Securities by the Issuer and Affiliated Purchasers

On August 24, 2010, the Corporation announced a stock repurchase program under which the Corporation is authorized to repurchase up to $25.0 million of the Corporation's common stock, of which $10.5 million was used to purchase the Corporation's common stock. On July 2, 2012, the Board of Directors authorized an increase to the existing stock repurchase program that allows the Corporation to again purchase back up to a maximum of $25.0 million of the Corporation's common stock. Approximately $19.7 million remained available under the program as of December 31, 2015. The stock repurchase program does not have an expiration date and may be limited, terminated or extended at any time without prior notice. The Corporation did not repurchase shares under this program for the three months ended December 31, 2015.

Additionally, the Corporation may redeem shares from employees upon vesting of the Corporation's stock awards for minimum statutory tax withholding purposes and exercise cost of stock options. The Corporation redeemed 2,607 shares of vested awards during the three months ended December 31, 2015.

The following table summarizes our share repurchase activity by month for the three months ended December 31, 2015:

Period	Total Number of Shares Purchased	Weighted Average Price Paid per Share	Total Number of Shares Purchased as	Approximate Dollar Value of Shares that may

				Part of a Publicly Announced Plans or Programs (2)	yet be Purchased under the Plans or Programs
					(in millions)
October 1, 2015 - October 31, 2015	-	(1)	$ -	-	$ 19.7
November 1, 2015 - November 30, 2015	2,607	(1)	34.35	-	19.7
December 1, 2015 - December 31, 2015	-	(1)	-	-	19.7

(1) The Corporation repurchased 2,607 shares of common stock in connection with the vesting of certain stock awards to cover minimum statutory withholding taxes.

(2) On August 24, 2010, the Board of Directors announced a share repurchase program whereby the Corporation is authorized to purchase up to $25.0 million of the Corporation's common stock, of which $10.5 million was used. On July 2, 2012, the Board of Directors authorized an increase to the remaining portion of the existing share repurchase program that allows the Corporation to again repurchase up to a maximum of $25.0 million of the Corporation's common stock. The Corporation did not repurchase any common stock shares under this program during the three months ended December 31, 2015.

Item 6. Selected Financial Data

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

	Years Ended December 31,				
	2011	2012	2013	2014	2015
Income statement data:					
Revenues	$2,081.1	$1,832.6	$1,757.9	$1,894.5	$2,028.5
Cost of goods sold	1,786.2	1,532.4	1,430.7	1,555.2	1,693.4
Gross profit	294.9	300.2	327.2	339.3	335.1
Selling, general and administrative	216.5	214.7	225.3	236.3	222.5
Amortization expense	11.0	12.3	15.4	20.1	28.6
Impairment of intangible assets	5.1				