SUNLINK HEALTH SYSTEMS INC
Form 10-K
September 27, 2011
Index to Financial Statements

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

Form 10-K

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

For the Fiscal Year Ended June 30, 2011

OR

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

For the transition period from to

Commission File No. 1-12607

SunLink Health Systems, Inc.

(Exact name of registrant as specified in its charter)

Ohio	**31-0621189**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**

900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339

(Address of principal executive offices)

Registrant s telephone number, including area code: (770) 933-7000

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

Title of each Class	**Name of each Exchange on which registered**
Common Shares without par value	NYSE Amex Equities

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

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 x

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

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 (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of the 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 Yes ¨ No x

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

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

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

At the close of business on September 23, 2011, there were 9,456,869 shares of the registrant s common shares without par value outstanding. The aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the closing price on December 31, 2010 of the registrant s common shares as reported by NYSE Amex Equities stock exchange amounted to $7,323,000.

Index to Financial Statements

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant s definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Shareholders of SunLink Health Systems, Inc., scheduled to be held on November 7, 2011, have been incorporated by reference into Part III of this Report. The Proxy Statement or an amendment to this Annual Report will be filed with the Securities and Exchange Commission within 120 days after June 30, 2011.

Index to Financial Statements

Certain Cautionary Statements

FORWARD-LOOKING STATEMENTS

This Annual Report and the documents that are incorporated by reference in this Annual Report contain certain forward-looking statements within the meaning of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that do not relate solely to historical or current facts and may be identified by the use of words such as may, believe, will, expect, project, estimate, anticipate, plan or continue. These forward-looking statements are plans and expectations and are subject to a number of risks, uncertainties and other factors which could significantly affect current plans and expectations and our future financial condition and results. These factors, which could cause actual results, performance and achievements to differ materially from those anticipated, include, but are not limited to:

General Business Conditions

general economic and business conditions in the U.S., both nationwide and in the states in which we operate;

the competitive nature of the U.S. community hospital, homecare, and specialty pharmacy businesses;

demographic changes in areas where we operate;

the availability of new long-term financing to replace our current credit agreement lender;

the availability of cash or borrowings to fund working capital, renovations, replacement, expansion and capital improvements at existing healthcare and specialty pharmacy facilities and for acquisitions and replacement of such facilities;

changes in accounting principles generally accepted in the U.S.; and,

fluctuations in the market value of equity securities including SunLink common shares;

Operational Factors

inability to operate profitably in one or more segments of the healthcare business;

the availability of, and our ability to attract and retain, sufficient qualified staff physicians, management, nurses, pharmacists and staff personnel for our operations;

timeliness and amount of reimbursement payments received under government programs;

increases in interest rates under debt agreements;

the inability to refinance existing indebtedness and potential defaults under existing indebtedness;

restrictions imposed by debt agreements;

the cost and availability of insurance coverage including professional liability (e.g., medical malpractice) and general liability insurance;

the efforts of insurers, healthcare providers, and others to contain healthcare costs;

the impact on hospital services of the treatment of patients in lower acuity healthcare settings, whether with drug therapy or via alternative healthcare services, such as surgery centers or urgent care centers;

changes in medical and other technology;

risks of changes in estimates of self insurance claims and reserves;

increases in prices of materials and services utilized in our Healthcare Facilities and Specialty Pharmacy Segments;

Index to Financial Statements

increases in wages as a result of inflation or competition for management, physician, nursing, pharmacy and staff positions;

increases in the amount and risk of collectability of accounts receivable, including deductibles and co-pay amounts; and,

the functionality or costs with respect to our management information system for our Healthcare Facilities and Specialty Pharmacy Segments, including both software and hardware;

the availability and competition from alternative drugs or treatments provided by our Specialty Pharmacy Segment;

Liabilities, Claims, Obligations and Other Matters

claims under leases, guarantees and other obligations relating to discontinued operations, including sold facilities, retained or acquired subsidiaries and former subsidiaries;

potential adverse consequences of known and unknown government investigations;

claims for product and environmental liabilities from continuing and discontinued operations;

professional, general and other claims which may be asserted against us; and

natural disasters and weather-related events such as earthquakes, flooding, snow, ice and wind damage and population evacuations affecting areas in which we operate.

Regulation and Governmental Activity

existing and proposed governmental budgetary constraints;

the regulatory environment for our businesses, including state certificate of need laws and pharmacy licensing laws and regulations, rules and judicial cases relating thereto;

anticipated adverse changes in the levels and terms of government (including Medicare, Medicaid and other programs) and private reimbursement for SunLink s healthcare facilities and specialty pharmacy services including the payment arrangements and terms of managed care agreements;

changes in or failure to comply with Federal, state or local laws and regulations affecting our Healthcare Facilities and Specialty Pharmacy Segments; and,

the possible enactment of Federal healthcare reform laws or reform laws in states where we operate hospital and pharmacy facilities (including Medicaid waivers, competitive bidding and other reforms).

Acquisition and Merger Related Matters

the availability and terms of capital to fund acquisitions, improvements, renovations or replacement facilities;

impairment or uncollectibility of certain acquired assets;

assumed liabilities discovered subsequent to an acquisition;

our ability to integrate acquired healthcare businesses and implement our business strategy; and

competition in the market for acquisitions of hospitals and healthcare businesses.

The foregoing are significant factors we think could cause our actual results to differ materially from expected results. However, there could be additional factors besides those listed herein that also could affect SunLink in an adverse manner.

Index to Financial Statements

You should read this Annual Report completely and with the understanding that actual future results may be materially different from what we expect. You are cautioned not to unduly rely on forward-looking statements when evaluating the information presented in this Annual Report or our other disclosures because current plans, anticipated actions, and future financial conditions and results may differ from those expressed in any forward-looking statements made by or on behalf of SunLink.

We have not undertaken any obligation to publicly update or revise any forward-looking statements. All of our forward-looking statements speak only as of the date of the document in which they are made or, if a date is specified, as of such date. We disclaim any obligation or undertaking to provide any updates or revisions to any forward-looking statement to reflect any change in our expectations or any changes in events, conditions, circumstances or information on which the forward-looking statement is based. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the foregoing factors and the other risk factors set forth elsewhere in this report.

Index to Financial Statements

PART I

Item 1. ***Business (all dollar amounts in thousands except share, per share and revenue per equivalent admission amounts)***

Overview

We are SunLink Health Systems, Inc. Unless the context indicates otherwise, all references to SunLink, we, our, ours, us and the Company to SunLink Health Systems, Inc. and our consolidated subsidiaries. We are a provider of healthcare services in certain markets in the United States. References to our specific operations refers to operations conducted through our subsidiaries and references to we, our, ours, and us such context refers to the operations of our subsidiaries. Our business is composed of two business segments, the Healthcare Facilities Segment and the Specialty Pharmacy Segment. Through our subsidiaries, we operate a total of six community hospitals in three states. Five of the community hospitals are owned and one is leased. Our community hospitals are acute care hospitals and have a total of 342 licensed beds. As part of our community hospital operations, we currently also operate (a) three nursing homes in two states, each of which is located adjacent to, or in close proximity with, one of our community hospitals, and (b) one home healthcare agency operated from one of our community hospitals. Our nursing homes have a total of 261 licensed beds. We also own a hospital building with a total of 60 licensed beds that we lease to a third party, which owns the hospital license for the facility, with an option to purchase. Through a subsidiary acquired in April 2008, we also operate a specialty pharmacy business with four service lines. Our healthcare operations are conducted through our direct and indirect subsidiaries, including SunLink Healthcare LLC (SHL), HealthMont LLC (HealthMont) and SunLink ScriptsRx, LLC (ScriptsRx).

Our executive offices are located at 900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339, and our telephone number is (770) 933-7000. Our website address is www.sunlinkhealth.com. Information contained on our website does not constitute part of this report. Any materials we file with the Securities and Exchange Commission (SEC) may be read at the SEC s Public Reference Room at 100 F Street, NE, Room 1580 Washington, DC 20549. Information on the operation of the Public Reference Room may be obtained by calling the SEC at 1-800-SEC-0330. Certain materials we file with the SEC may also be read and copied at or through our website or at the Internet website maintained by the SEC at www.sec.gov.

History

We are an Ohio corporation and were incorporated in June 1959. In fiscal 2001 we redirected our business strategy toward healthcare services in the United States. On February 1, 2001, we purchased five community hospitals, leasehold rights for a sixth hospital and the related businesses of all six hospitals. On October 3, 2003, we acquired two additional hospitals through our acquisition of HealthMont, Inc. In June 2004, we sold our Mountainside Medical Center (Mountainside) facility, a 35-bed hospital located in Jasper, GA. In April 2008, our SunLink ScriptsRx, LLC subsidiary acquired Carmichael s Cashway Pharmacy, Inc. (Carmichael). Carmichael provides services to patients in rural communities in southwest Louisiana and eastern Texas. In September 2009, we sold three of our home health businesses. In March 2011, we sold our Clanton Hospital (Clanton) operations but retained ownership of the hospital building. The hospital building is leased to the buyer of Clanton.

Business Strategy: Strategic Alternatives, Operations, Acquisitions and Dispositions

SunLink s business strategy is to focus its efforts on internal operations of its existing healthcare facilities and its pharmacy business, supplemented by growth from potential healthcare acquisitions, including but not limited to hospitals, physician clinics, ambulatory surgery centers, nursing homes and pharmacy businesses. However, as was the case in 2004 with our Mountainside Medical Center hospital, in

September 2009 with the sale of three home health agencies and in March 2011 with the sale of our Clanton Hospital operations, we

Index to Financial Statements

consider dispositions of one or more of our facilities or operations based on a variety of factors including asset values, return on investments, competition from existing and potential facilities, capital improvement needs, corporate strategy and other corporate objectives.

On April 8, 2011, SunLink Health Systems, Inc. announced that it has reached a preliminary agreement and executed a letter of intent with Foundation HealthCare Affiliates, LLC (Foundation) and New Age Fuel, Inc. (New Age), and Foundation Investment Affiliates I, LLC (FIA) for the non-cash merger of certain Foundation and New Age, FIA, subsidiaries and affiliates with and into newly formed acquisition subsidiaries of SunLink. The contemplated transaction is subject to a number of conditions, including completion of due diligence by each of the parties, negotiation and execution of a definitive merger agreement and consent of lenders. The subsidiaries and affiliates of Foundation contemplated to be merged into the SunLink acquisition subsidiaries per the letter of intent own minority equity interests in and manage 14 ambulatory surgery centers in seven states (Louisiana, Maryland, New Jersey, Ohio, Oklahoma, Pennsylvania and Texas), own a majority interest in and manage one general acute care hospital and manage a second acute care hospital, both of which are located in Texas. Three medical real properties, which are occupied by Foundation entities as well as other tenants in Oklahoma, are majority owned by New Age and FIA and would also be merged into the SunLink acquisition subsidiaries.

Under the Letter of Intent, the merger consideration to be issued by SunLink to the owners and affiliates of Foundation and New Age was contemplated to consist of approximately 1,560,000 SunLink common shares, approximately 133,000 shares of SunLink s non-voting cumulative 5% Series A Preferred Stock, liquidation value $100.00 per share; approximately 277,000 shares of SunLink s non-voting non-cumulative 4% Series B Preferred Stock, liquidation value $100.00 per share; and 3,000,000 Series A Warrants each of which would entitle the holder for three years to buy one SunLink common share at an exercise price of $6.00. In connection with the mergers, as was contemplated under the Letter of intent, SunLink would declare a stock dividend, issuing to its existing holders of common shares (as of a record date to be established), approximately 133,600 shares of its Series A Preferred Stock, approximately 79,900 shares of its Series B Preferred Stock, and 3,000,000 Series B Warrants each of which will entitle the holder for three years to buy one SunLink common share at an exercise price of $6.50.

Subsequent to execution of the letter of intent, SunLink effected a private placement of 1.3 million plus common shares at an average of approximately $1.90 per share with certain of its officers and directors and/or their affiliates. The proceeds of the private placement of approximately $2,500 were used, together with other available operating funds, to make an $8,000 pre-payment on the term loan outstanding under SunLink s 2008 Credit Facility in order to, among other things, obtain the extension of the maturity of that facility and adjust certain financial covenants to bring SunLink into compliance thereunder. Given the inadequate number of authorized but unissued SunLink common shares presently remaining after the private placement, it is currently anticipated that, among other things, the merger consideration consisting of SunLink preferred shares will be correspondingly increased and the composition of the Foundation, New Age and FIA, subsidiaries and affiliates to be merged will be modified in certain particulars to be agreed.

No approval by the shareholders of SunLink is required for the proposed mergers. However, the Series B Preferred Stock will be automatically converted into common shares of SunLink at a to be agreed conversion price , such conversion to be effected upon receipt of approval of the common shareholders of SunLink. Similarly, the Series A and Series B Warrants would not be exercisable unless and until the exercise of such warrants for SunLink common shares is approved by the common shareholders of SunLink. Promptly following closing of the mergers, SunLink intends to seek such approval by its common shareholders of conversion of the Series B Preferred Stock into SunLink common shares and of the right of the holders to the exercise of the Series A and Series B Warrants after the mergers.

Upon completion of the mergers, the combined company would expect to change its name to Foundation SunLink Healthcare Affiliates, Inc. In addition, it is anticipated that two persons designated by Foundation/New

Index to Financial Statements

Age will join the board of directors of SunLink. Foundation SunLink is intended to be a premier healthcare facilities company positioned to respond to the changing marketplace developing under healthcare reform. Foundation SunLink s mission will be to more closely align the interests of physicians, hospitals and related healthcare facilities to improve the quality of care and control healthcare costs in communities it serves. It is anticipated that Foundation SunLink will focus on growth through physician-centric hospitals, surgery centers and related ancillary service providers, including its existing hospitals and surgery centers, plus the aggressive acquisition and development of additional physician-centric hospitals, surgery centers and ancillary service providers nationwide.

No definitive agreement has been executed in relation to the contemplated mergers and there can be no assurance that the proposed transactions will in fact be consummated or, if consummated, that the terms and conditions referenced herein will not be changed.

Operations Strategy

Our operational strategy is focused on efforts to improve operations and generate internal growth. Our primary operational strategy for our community hospitals is to improve the operations and profitability of such hospitals by reducing out-migration of patients, recruiting physicians, expanding services and implementing and maintaining effective cost controls. Our operational strategy for our nursing homes and home health agency is similar to that for our community hospitals and is focused on expanding services and implementing and maintaining effective cost controls. Our operational strategy for our Specialty Pharmacy segment is focused on increasing market share, expanding services, and implementing and maintaining effective cost controls.

Acquisition and Disposition Strategy

Although the Company s situation could change, based on its current financial position as well as uncertainties in the healthcare industry, the Company is not actively seeking acquisitions for its Healthcare Facilities or Specialty Pharmacy Segments. However, during the last fiscal year, we evaluated certain rural and exurban hospitals and healthcare businesses, which were for sale and monitored other selected healthcare acquisition targets which we believed might become available for sale.

When we seek to acquire pharmacy businesses, our acquisition strategy is to acquire such businesses in rural or exurban markets where the acquisition is complementary to our existing pharmacy services and in new markets where the scale of the acquisition is sufficient to provide a foundation to grow Specialty Pharmacy in that area.

Although we have no current plans to do so, from time to time we may consider the acquisition of other complementary based healthcare businesses, outside of our existing business segments, which are or may become available for acquisition.

We continue to engage in similar evaluation and monitoring activities with respect to hospitals, nursing homes, home health businesses, pharmacy and other rural or exurban healthcare businesses, which are or may become available for acquisition.

Historically, we targeted the rural or exurban community hospital market because we believed it provided an attractive sector for investment in healthcare facilities. We continue to believe hospitals and other healthcare businesses in our markets generally experience (1) less direct competition, (2) lower managed care penetration, (3) more manageable inflationary pressure with respect to certain costs, (4) higher staff, employee and community loyalty, and (5), in certain cases, opportunity for future growth. The focus of acquisition activities will depend on our evaluation of relative opportunities for growth and profitability within the business segments and services lines of our existing operations, the capital needs of our existing and potential operations within such existing and potential segments and services lines, current and potential changes in government regulation and reimbursement rules, competition for potential acquisitions and valuations of existing or potential new healthcare related facilities and operations and other factors.

Index to Financial Statements

Extensive competition may exist for healthcare facility acquisitions, primarily from for-profit management companies and not-for-profit entities which may have greater financial and other resources than SunLink. Competition for the acquisition of non-urban acute-care hospitals and other healthcare facilities could have an adverse impact on our ability to acquire such hospitals and other healthcare facilities on favorable terms or at all.

We believe there may be opportunities for acquisitions or dispositions of individual hospitals in the future due to, among other things, continued negative trends in certain government reimbursement programs and other factors. We also believe there may be opportunities for the acquisition or disposition of individual or groups of hospitals in the future as other for-profit hospital operators seeking to re-align the focus of their portfolios.

Opportunities to acquire not-for-profit hospitals remain uncertain. Even if such opportunities improve, in recent years, the legislatures and attorneys general of several states (including Georgia and other states which we believe might have suitable acquisition targets) have shown a heightened level of interest in reviewing transactions involving the sale of not-for-profit hospitals. The legal authority for such review is generally known as Conversion Legislation. Although the level of authority for, and interest in, such reviews varies from state to state, the trend is toward increased governmental authority for review and review of such transactions including, in some cases, the imposition of requirements on the seller, the buyer or both as a condition to the approval of a not-for-profit corporation selling a healthcare facility. Accordingly, even if the opportunity or desirability of acquiring not-for-profit hospitals improves, governmental review may make it more difficult or expensive to complete any such acquisitions.

Our acquisition strategy for nursing homes operations is to acquire businesses in areas which are complementary to either our existing hospitals or our pharmacy business or which are located in markets which we perceive as desirable.

As noted above, from time to time we may consider the disposition of one or more of our healthcare facilities, service lines or business segments, particularly if we determine that the operating results or potential growth of such facility, service line or segment no longer meet our business objectives.

Healthcare Facilities Operations

SunLink s Healthcare Facilities Segment is composed of three operational areas:

- Our six community hospitals;
- Our three nursing homes, each of which is located adjacent to, or in close proximity with a corresponding SunLink community hospital; and
- One hospital related home health agency, which operates for a corresponding SunLink community hospital;

In addition, we own one hospital facility which is leased to a third party, which owns the hospital license for the facility, with an option to purchase.

Through our subsidiaries, we operate a total of six community hospitals in three states. Five of the community hospitals are owned and one is leased. SunLink s community hospitals are acute care hospitals and have a total of 342 licensed beds. We also own one 60 licensed bed hospital building that is leased to a third party with an option to purchase at the end of the lease. In connection with our community hospital operations in certain communities, we also operate (a) three nursing homes located in two states: each of our current nursing homes is located adjacent to our community hospitals, and (b) one home healthcare agency operated from one of our community hospitals. Our nursing homes have a total of 261 licensed beds.

Owned and Leased Hospitals

All of our hospitals which we operate are owned except Missouri Southern Healthcare, which is a leased hospital. The following sets forth certain information with respect to each of our six community hospitals which we operate:

Chestatee Regional Hospital (Chestatee), located in Dahlonega, Lumpkin County, Georgia, is a 49-licensed-bed, acute-care hospital accredited by the Joint Commission on Accreditation of Healthcare

Index to Financial Statements

Organizations (the JCAHO). It includes a 12-bed obstetric department, a four-bed intensive care unit (ICU) and a 33-bed medical/surgical/pediatrics unit. Chestatee is the only hospital in its primary service area of Lumpkin and Dawson Counties.

North Georgia Medical Center (North Georgia), located in Ellijay, Gilmer County, Georgia, consists of a JCAHO accredited 50-licensed-bed, acute-care hospital and Gilmer Nursing Home, a 100-bed skilled nursing facility. North Georgia is the only hospital in Gilmer County. The Company has a 24-bed Certificate of Need (CON) to replace the existing hospital and a 10-bed inpatient geriatric psychiatric program.

Trace Regional Hospital (Trace), located in Houston, Chickasaw County, Mississippi, consists of a JCAHO accredited 84-licensed-bed, acute-care hospital and Floy Dyer Manor Nursing Home, a 66-bed nursing home. Trace is the only hospital in Chickasaw County.

Missouri Southern Healthcare (Missouri Southern), located in Dexter, Stoddard County, Missouri, is a 50-licensed-bed, acute-care hospital. It includes a four-bed ICU. It is the only hospital in Dexter, Missouri. The lease expires in 2019. It operates a home-health agency.

Callaway Community Hospital (Callaway), located in Fulton, Callaway County, Missouri, is a 49-licensed-bed, JCAHO accredited, acute-care hospital. Callaway is the only hospital in Callaway County.

Memorial Hospital of Adel (Adel), located in Adel, Cook County, Georgia, consists of a JCAHO accredited 60-licensed-bed, acute-care hospital and Memorial Convalescent Center, a 95-bed skilled nursing facility. Adel is the only hospital in Cook County.

We also own the Chilton Medical Center (Chilton) hospital building located in Clanton, Chilton County, Alabama which we lease to a third party. Chilton is a 60-licensed-bed, JCAHO accredited, acute-care hospital. The third party has the option to purchase the facility. Chilton is the only hospital in Chilton County.

Hospital Operations

Utilization of Local Hospital Management Teams

We believe that the long-term potential of our hospitals is dependent on their ability to offer appropriate healthcare services and effectively recruit and retain physicians. Each SunLink hospital has developed and continuously seeks to implement an operating plan designed to improve efficiency and increase revenue including, but not limited to, the expansion of services offered by the hospital and the recruitment of physicians to the community.

Each hospital management team is comprised of a chief executive officer, chief financial officer and chief nursing officer. The quality of the on-site hospital management team is critical to the success of our hospitals. The on-site management team is responsible for implementing the operating plan under the guidance of SunLink s senior management team. Each hospital management team participates in a performance-based compensation program based upon the achievement of operational, clinical and financial goals set forth in the operating plan.

Each hospital management team is responsible for the day-to-day operations of its hospital. Our corporate staff provides support services, assistance, and advice to each hospital in certain areas, including strategic planning, physician recruiting and relationship management, corporate compliance, reimbursement, information systems, human resources, accounting, cash management, capital financing, tax and insurance. Financial controls are maintained through the utilization of standardized policies and procedures and monitoring by corporate staff. Our hospitals have contracted with the HealthTrust Group Purchasing Organization, a purchasing group used by a large number of community hospitals, for certain supplies and equipment. We promote communication among our hospitals and management teams so that local expertise and improvements can be shared among all of our facilities.

Index to Financial Statements

Expansion of Services and Facilities

We seek to add services at our hospitals on an as-needed basis in order to improve access to quality healthcare services in the communities we serve, with the ultimate goal of reducing the out-migration of patients to other hospitals or alternate service providers. Additional and expanded services and programs, which may include specialty inpatient and outpatient services, are often dependent on recruiting physicians; therefore, physician recruiting goals are important to our ability to expand services. Capital investments in technology and facilities are often necessary to increase the quality and scope of services provided to the communities. Additional and expanded services and improvements add to each hospital s quality of care and reputation in the community, reducing out-migration and increasing patient referrals and revenue. SunLink provides emergency room services in each of our hospitals. We seek to maintain a quality, patient-friendly emergency room because we view the emergency room as each facility s window to the community and a critical component of its local service offering.

Medical Staff

The number and quality of physicians affiliated with a hospital directly affects the quality and availability of patient care and the reputation of the hospital. Physicians generally may terminate their affiliation with a hospital at any time. We seek to retain primary care physicians of varied physician specialties on the medical staffs of our hospitals and to attract other qualified physicians. SunLink believes physicians refer patients to a hospital primarily on the basis of the quality of services the hospital renders to patients and physicians; the quality of other physicians on the medical staff; the location of the hospital; and the quality of the hospital s facilities, equipment and employees. Accordingly, SunLink strives to provide quality facilities, equipment, employees and services for physicians and their patients.

Physician Recruiting

Each SunLink hospital management team is responsible for assessing the need for additional physicians, including the number and specialty of additional physicians needed by the hospital s community. Each of our local hospital management teams, with the assistance of outside recruiting firms and corporate staff, identifies and seeks to attract specific physicians to its hospital s medical staff. While our hospitals historically have not employed physicians, we have moved forward to better align with physicians through employment relationships. The new business model for many hospitals and hospital systems is to gain closer alignment with physicians both clinically and financially. The hospital generally guarantees a newly recruited physician a minimum level of gross receipts during an initial period, generally one year, and assists the physician s transition into the community. The physician is required to repay some or all of the amounts paid under such guarantee if the physician leaves the community within a specified period. Currently, 28 physicians are employed by the hospitals and 2 are under physician guarantee contracts. We continually evaluate each doctor and may terminate employment based on doctor performance and the needs of each facility. The Company believes physician recruiting is becoming more challenging and will continue to do so due to healthcare reform and market forces. The Company believes the costs of recruiting and retaining physicians will increase as more physicians are employed and salaries and support costs increase.

Quality Assurance

Each SunLink hospital implements quality assurance procedures to monitor the level and quality of care provided to its patients. Each hospital has a medical director who supervises and is responsible for the quality of medical care provided and a medical advisory committee comprised of physicians who review the professional credentials of physicians applying for medical staff privileges at the hospital. The medical advisory committee also reviews and monitors surgical outcomes along with procedures performed and the quality of the logistical, medical and technological support provided to the physicians. Each hospital periodically conducts surveys of its patients, either during their stay at the hospital or subsequently by mail, to identify potential areas of improvement. Each SunLink hospital, except the leased hospital in Dexter,

Missouri, is accredited by the Joint Commission of Accreditation of Healthcare Organizations, also known as JCAHO.

Index to Financial Statements

Operating Statistics

The following table sets forth certain operating statistics for SunLink s healthcare facilities included in continuing operations as of June 30, 2011 for the periods indicated.

	Fiscal Years Ended June 30,		
	2011	2010	2009
Hospitals owned or leased at end of period	6	6	6
Licensed hospital bed (at end of period)	342	342	342
Hospital beds in service (at end of period)	283	292	292
Nursing home beds in service (at end of period)	261	261	261
Admissions	6,197	6,818	7,683
Equivalent Admissions(1)	18,702	20,062	20,343
Average Length of Stay(2)	3.5	3.5	3.5
Patient days	21,388	24,149	26,736
Adjusted patient days(3)	63,821	70,084	70,013
Occupancy rate (% of licensed beds)(4)	17.13%	19.35%	21.42%
Occupancy rate (% of beds in service)(5)	20.71%	22.66%	25.09%
Net patient service revenues (in thousands)	$ 141,241	$ 140,556	$ 135,431
Net outpatient service revenues (in thousands)	$ 59,299	$ 67,225	$ 63,689
Net revenue per equivalent admissions	$ 7,552	$ 7,006	$ 6,657
Net outpatient service revenues (as a % of net patient service revenues)	41.98%	47.83%	47.03%

(1) Equivalent admissions are a statistic used by management (and certain investors) as a general approximation of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenues and gross outpatient revenues and dividing the result by gross inpatient revenues. The equivalent admissions computation is intended to relate outpatient revenues to the volume measure (admissions) used to measure inpatient volume resulting in a general approximation of combined inpatient and outpatient volume.

(2) Average length of stay is calculated based on the number of patient days divided by the number of admissions.

(3) Adjusted patient days have been calculated based on a revenue-based formula of multiplying actual patient days by the sum of gross inpatient revenues and gross outpatient revenues and dividing the result by gross inpatient revenues for each hospital. Adjusted patient days is a statistic (which is used generally in the industry) designed to communicate an approximate volume of service provided to inpatients and outpatients by converting total patient revenues to a number representing adjusted patient days.

(4) Percentages are calculated by dividing average daily census by the average number of licensed beds.

(5) Percentages are calculated by dividing average daily census by the average number of beds in service.

Sources of Revenue

Each SunLink hospital receives payments for patient care from Federal Medicare programs, State Medicaid programs, private insurance carriers, health maintenance organizations, preferred provider organizations, TriCare, and from employers and patients directly. Medicare is a Federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a Federal-state program, administered by the states, that provides hospital and nursing home benefits to qualifying individuals who are unable to afford care. All of SunLink s hospitals are certified as healthcare services providers for persons covered by Medicare and Medicaid programs. TriCare is a Federal program for the healthcare of certain U.S. military personnel and their dependants. See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations .

Index to Financial Statements

The following table sets forth the percentage of patient days from various payors in SunLink s healthcare facilities for the periods indicated.

	Fiscal Years Ended June 30,		
	2011	2010	2009
Source			
Medicare	70.8%	71.4%	71.4%
Medicaid	11.5%	10.6%	9.6%
Private and Other Sources	17.7%	18.0%	19.0%
	100.0%	100.0%	100.0%

The following table sets forth the percentage of the net patient revenues from major payors in SunLink s hospitals.

	Fiscal Years Ended June 30,		
	2011	2010	2009
Source			
Medicare	43.2%	39.1%	40.2%
Medicaid	14.3%	12.9%	14.9%
Private and Other Sources	42.5%	48.0%	44.9%
	100.0%	100.0%	100.0%

Hospital revenues depend upon inpatient occupancy levels, the extent to which ancillary services and therapy programs are ordered by physicians and provided to patients, and the volume of outpatient procedures. Reimbursement rates for routine inpatient services vary significantly depending on the type of service (e.g., acute care, intensive care or psychiatric care) and the geographic location of the hospital. The percentage of patient revenues attributable to outpatient services has increased in recent years, primarily as a result of medical technology advances that allow more services to be provided on an outpatient basis and from increased pressures from Medicare, Medicaid and private insurers to reduce hospital stays and provide services, where possible, on a less expensive outpatient basis.

Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid and some private insurer plans, health maintenance organization (HMO) plans and preferred provider organizations(PPO) plans, but are responsible to the extent of any exclusions, deductibles or co-insurance features of their coverage. The amount of such exclusions, deductibles and co-insurance has been increasing in recent years. Collection of amounts due from individuals typically is more difficult than from governmental or third-party payors. Further, amounts received under the Medicare and Medicaid programs generally are significantly less than the established charges of most hospitals, including our own, for the services provided. Likewise, HMOs and PPOs generally seek and obtain discounts from the established charges of most hospitals. See Item 1. Business Government Reimbursement Programs Medicare/Medicaid Reimbursement .

Competition

Among the factors which we believe influence patient selection among hospitals in our markets are:

The appearance and functionality of the healthcare facilities;

The quality and demeanor of professional staff and physicians; and

The participation of the hospital in plans which pay a portion of the patient s bill.

Index to Financial Statements

Such factors are influenced heavily by the quality and scope of medical services, strength of referral networks, hospital location and the price of hospital services. Our hospitals may face less competition in their immediate patient service areas than would be expected in larger communities because they are the primary provider of healthcare services in their respective communities. However, our hospitals usually face competition from larger tertiary care centers and, in some cases, other rural, exurban, suburban or, in limited circumstances, urban hospitals, some of which offer more specialized services. The competing hospitals may be owned by governmental agencies or not-for-profit entities supported by endowments and charitable contributions and may be able to finance capital expenditures on a tax-exempt basis. Such governmental-owned and not-for-profit hospitals, as well as various for-profit hospitals operating in the broader service area of our hospitals, likely have greater access to financial resources than do our hospitals.

Managed Care

Each SunLink hospital is affected by its ability to negotiate service contracts with purchasers of group healthcare services. HMOs and PPOs attempt to direct and control the use of hospital services through managed care programs. In addition, employers and traditional health insurers increasingly are seeking to contain costs through negotiations with hospitals for managed care programs and discounts from established charges. Generally, hospitals compete for service contracts with group healthcare service purchasers on the basis of market reputation, geographic location, quality and range of services, quality of medical staff, convenience and price.

The importance of obtaining contracts with managed care organizations varies from market to market, depending on the market strength of such organizations. Management believes that, on an industry basis, managed care contracts generally are less important in our markets than in urban and suburban markets where there is typically a higher level of managed care penetration. Nevertheless, a significant portion of hospital patients in our communities are covered by managed care or other reimbursement programs, all of which generally pay less than established charges for hospital services.

The healthcare industry as a whole faces the challenge of continuing to provide quality patient care while managing rising costs, facing strong competition for patients, and adjusting to a continued general reduction of reimbursement rates by both private and government payors. Both private and government payors continually seek to reduce the nature and scope of services which may be reimbursed. Healthcare reform at both the Federal and state level generally has created pressure to reduce reimbursement rates. Changes in medical technology, existing and future legislation, regulations and interpretations, and competitive contracting for provider services by private and government payors, may require changes in our facilities, equipment, personnel, rates and/or services in the future.

Efforts to Control Healthcare Costs

The hospital industry, including all of SunLink s hospitals, continues to have significant unused capacity. Inpatient utilization, average lengths of stay and average inpatient occupancy rates continue to be affected negatively by payor-required pre-admission authorization, utilization review, and payment mechanisms designed to maximize outpatient and alternative healthcare delivery services for less acutely ill patients and to limit the cost of treating inpatients. Admissions constraints, payor pressures, and increased competition are likely to continue. Historically we have responded to such trends by adding and expanding outpatient services, upgrading facilities and equipment, offering new programs and adding or expanding certain inpatient and ancillary services. Currently we expect to continue to respond to such trends in a similar manner subject to the availability of capital resources and our evaluation of the continued utility of such historical responses.

Index to Financial Statements

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the Affordable Care Act or ACA) were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. The ACA dramatically alters the United States health care system and is intended to decrease the number of uninsured Americans and reduce overall health care costs. The ACA attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, including disproportionate share payments, expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The ACA also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. Because a majority of the measures contained in the ACA do not take effect until 2013 and 2014 and most of the rules and regulations that implement the provisions of the ACA have not been adopted or proposed, it is difficult to predict the impact the ACA will have on our facilities. However, it is possible that the implementation or interpretation of such rules and regulations or the provisions of the ACA could have an adverse effect on our financial condition and results of operations.

Government Reimbursement Programs

A significant portion of SunLink s healthcare facilities net revenues are dependent upon reimbursement from Medicare and Medicaid. The Centers for Medicare and Medicaid Services or CMS is the federal agency which administers Medicare, Medicaid and the Children s Health Insurance Program (CHIP). Although the Federal government generally reviews payment rates under its various programs annually, changes in reimbursement rates under such programs, including Medicare and Medicaid, generally occur based on the fiscal year of the Federal government which currently begins on October 1 and ends on September 30 of each year.

Medicare Inpatient Reimbursement

The Medicare program pays hospitals under the provisions of a prospective payment system for inpatient services. Under the inpatient prospective payment system, a hospital receives a fixed amount for inpatient hospital services based on the established fixed payment amount per discharge for categories of hospital treatment, known as diagnosis related groups (DRGs). Each patient admitted for care is assigned to a DRG based upon his or her primary admitting diagnosis. Every DRG is assigned a payment rate by the government based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. DRG payments do not consider a specific hospital s costs, but are national rates adjusted for area wage differentials and case-mix indices.

DRG rates are usually adjusted by an update factor each Federal fiscal year. The percentage increases to DRG payment rates for the last several years have been lower than the percentage increases in the related cost of goods and services provided by general hospitals. The index used to adjust the DRG payment rates is based on a price statistic, known as the CMS Market Basket Index, reduced by congressionally mandated reduction factors.

DRG rate increases were 2.1% and 2.35% for Federal fiscal years (FFY) 2010 and 2011, respectively, and currently is 1.1% for FFY 2012. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future Federal fiscal years at rates that would be based on the market basket index, which in certain years have been, and in the future may be, subject to reduction factors. In FFY 2012 the market basket rate currently is affected by two such reduction factors. First as required by the Affordable Care Act, the market basket rate is reduced by 0.25%.

Second, CMS is applying a documentation and coding adjustment to recoup a portion of excess aggregate payments in FFY 2008 and FY 2009 that did not reflect actual increases in patients severity of illness. Under legislation passed in 2007, CMS is required to recoup the entire amount of FFY 2008

Index to Financial Statements

and 2009 excess spending resulting from changes in hospital coding practices no later than FFY 2012. If the update factor does not adequately reflect increases in SunLink s cost of providing inpatient services, our financial condition or results of operations could be negatively affected.

The ACA made a number of changes to Medicare which include but are not limited to:

Reduction of market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. The market basket was reduced by 0.25% for both FFY 2010 and 2011, and will be reduced by 0.10% in FFYs 2012 and 2013, by 0.30% in FFY 2014, by 0.20% in 2015 and 2016, and by 0.75% in FFYs 2017-2019.

Reduction of Medicare payments that would otherwise be made to hospitals by specified percentages to account for preventable hospital readmissions, effective October 1, 2012.

Extension of the Medicare Dependent Hospital Program until September 30, 2012.

Expansion, on a temporary basis, of the low volume hospital inpatient payment adjustment to include hospitals that are more than 15 miles from other healthcare facilities and have less than 1,600 discharges per year. The new temporary criteria are effective for FFYs 2011 and 2012.

Each of SunLink s hospitals is an eligible hospital under one or more provisions of ACA.

Medicare Outpatient Reimbursement

Most outpatient services provided by general hospitals are reimbursed by Medicare under the outpatient prospective payment system. This outpatient prospective payment system is based on a system of Ambulatory Payment Classifications (APC). Each APC is designed to represent a bundle of outpatient services, and each APC is assigned a fully prospective reimbursement rate. Medicare pays a set price or rate for each APC group, regardless of the actual cost incurred in providing care. Each APC rate generally is subject to adjustment each year by an update factor based on a market basket of services index. For calendar years 2008, 2009, 2010 and 2011 the update factors were 3.3%, 3.6%, 2.1% and 2.6% respectively. If the update factor does not adequately reflect increases in SunLink s cost of providing outpatient services, our financial condition or results of operations could be negatively affected.

Medicare Bad Debt Reimbursement

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by a fiscal intermediary from the prior cost report filing.

Bad debts must meet the following criteria to be allowable:

the debt must be related to covered services and derived from deductible and coinsurance amounts; the provider must be able to establish that reasonable collection efforts were made;

the debt was actually uncollectible when claimed as worthless; and

sound business judgment established that there was no likelihood of recovery at any time in the future.

Amounts uncollectible from specific beneficiaries are charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 30%. Under this program, our hospitals received an aggregate of approximately $1,442, $1,823 and $988 for 2010, 2009 and 2008, respectively.

Index to Financial Statements

Medicare Disproportionate Share Payments

In addition to the standard DRG payment, the Social Security Act requires that additional Medicare payments be made to hospitals with a disproportionate share of low income patients. Beneficiary Improvement and Protection Act (BIPA) provisions, effective for services provided on and after April 1, 2001, stipulate that rural facilities with fewer than 100 beds with a disproportionate share percentage greater than 15% will be classified as a disproportionate share hospital entitled to receive a supplemental disproportionate share payment based on gross DRG payments. Since April 1, 2004, the effective rate has been 12.0% of DRG payments. All of our hospitals were classified as disproportionate share hospitals at June 30, 2011. Furthermore, the Affordable Care Act provides for material reductions in Medicare DSH funding. However, we estimate that Medicare disproportionate share payments represented only approximately 1% of our net patient service revenues for the years ended June 30, 2011, 2010 and 2009.

Medicaid Inpatient and Outpatient Reimbursement

Each state operates a Medicaid program funded jointly by the state and the Federal government. Federal law governs the general management of the Medicaid program, but there is wide latitude for states to customize Medicaid programs to fit local needs and resources. As a result, each state Medicaid plan has its own payment formula and recipient eligibility criteria.

In the recent past, the various states in which SunLink operates hospitals have initiated increased efforts to reduce Medicaid assistance payments. These efforts and reductions often are triggered by one or more of the following factors: an increased effort by CMS to decrease the federal share of payments for Medicaid beneficiaries and significant increases in program utilization resulting from increased enrollment or budgetary pressures on the applicable states. The Federal government s percentage share of each state s medical assistance expenditures under Medicaid is determined by a formula specified in Medicaid law referred to as the Federal Medical Assistance Percentage (FMAP).

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA) This law provides a temporary increase in the state FMAPs during a 9-calendar quarter recession adjustment period retroactively beginning October 1, 2008 and ending December 31, 2010.

Traditionally under the Medicaid law, each state s FMAP is determined by a formula based on the relationship of each state s per capita income to the national per capita income; the lower a state s per capita income, the higher its FMAP. The FMAP is determined for each fiscal year and applies for states expenditures during that fiscal year. As a result of the temporary ARRA increase in the FMAP, reductions in Medicaid programs which were scheduled to take effect on July 1, 2009 in various states where SunLink operates were postponed until January 1, 2011.

The State of Georgia, where SunLink operates three hospitals, has begun initiatives to decrease the Medicaid funds paid to providers. Georgia Medicaid pays providers for inpatient services in a manner similar to the Medicare prospective payment system in that hospitals receive a fixed fee for inpatient hospital services based on the established fixed payment amount per discharge for categories of hospital treatment, also known as DRGs. These Medicaid DRG payments do not consider a specific hospital s costs, but are statewide rates adjusted for each hospital s capital cost allotment.

Medicaid outpatient services are reimbursed with interim rates based on a facility specific cost to charge ratio. These interim payments are then adjusted subsequent to the end of the cost reporting period to an amount equal to 85.6% of the costs associated with providing care to the

Medicaid outpatient population.

In 2006, Georgia implemented a Medicaid HMO program and awarded contracts to private companies for the management and processing of certain Medicaid claims. The intent of the Medicaid HMO program is to curtail utilization and reduce rates paid by the State of Georgia. All of SunLink s facilities that operate in the

Index to Financial Statements

state of Georgia have secured contracts with all the HMO companies contracted by the state in their respective regions. Since the implementation of the Medicaid HMO program, all SunLink hospitals receive reimbursement from three different contractors instead of a single source. While the amounts of the inpatient payments have not changed since the contractors utilize the same payment rates, the timing of the receipt of the payments has changed due to the multiple payors. For outpatient services, our hospitals have contracts with the three HMO vendors and services are reimbursed at 102% of the current interim rate as determined by the Georgia Department of Community Health.

Adoption of Electronic Health Records

The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) was enacted into law on February 17, 2009 as part of the ARRA. The HITECH Act includes provisions designed to increase the use of electronic health records (EHR) by both physicians and hospitals. Beginning with FFY 2011 and extending through FFY 2016, eligible hospitals and critical access hospitals (CAHs) participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of its certified EHR technology. Conversely, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to reductions in reimbursements beginning in FFY 2015. On July 13, 2010, the Department of Health and Human Services (DHHS) released final meaningful use regulations for EHR. Meaningful use criteria are divided into three distinct stages; I, II and III. The final rules specify the initial criteria for: physicians, eligible hospitals, and CAHs necessary to qualify for incentive payments; calculation of the incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services, eligible hospitals and CAHs which fail to demonstrate meaningful use of certified EHR technology; and other program participation requirements.

Attestation of Medicare meaningful use requirements for the first year (October 1, 2010 September 30, 2011) began on April 18, 2011. Each of SunLink s six hospitals and its formerly owned Chilton Medical Center registered for the program with CMS and on April 18, 2011 all successfully attested compliance with Part I of the Medicare EHR incentive program for such first year. As of June 30, 2011, SunLink has accrued Medicare EHR incentive reimbursement of $6,952 for the six hospitals as of June 30, 2011 and $731 for its formerly owned Chilton Medical Center. The Company has received $7,731 in EHR Medicare incentive reimbursements for the six hospitals and $790 for its formerly owned Chilton Medical Center for the fiscal year then ended.

The Company has also successfully attested to the meaningful use requirements for Medicaid programs for its two Missouri Hospitals and its formerly owned Chilton Medical Center in Alabama, The Company accrued Medicaid EHR reimbursement for Mississippi and Missouri in the amount of $1,102 collectively and $141 for its formerly owned Chilton Medical Center. No amount has been accrued for Georgia Medicaid EHR incentive payments since the reimbursement program has not yet been established by the state. The amounts accrued are the estimates of the incentive payments for the periods earned through June 30, 2011.

We intend to continue to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for all available incentive payments. We believe our compliance will result in significant costs including professional services focused on successfully designing and implementing our EHR solutions along with costs associated with the hardware and software components of the project. As a result of our prior expenditures on information technology systems, our previously existing information technology systems already possessed certain components required for meaningful use of EHR technology. We continue to refine our budgeted costs and the expected reimbursement associated with our use of EHR technology. We currently estimate that, at a minimum, the incremental total costs and capital expenditures incurred to comply with the EHR regulations will be recovered through improved reimbursement amounts over the projected lifecycle of our EHR technology initiative, although such incremental costs and capital expenditures, have to a great degree, predated the reimbursements.

Index to Financial Statements

Government Reimbursement Program Administration and Adjustments

The Medicare, Medicaid and TriCare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review and changing governmental funding restrictions, all of which may materially increase or decrease program payments as well as affect the cost of providing services and the timing of payments under such programs.

All hospitals participating in the Medicare and Medicaid programs, whether paid on a reasonable cost basis or under a prospective payment system, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenues, costs and expenses associated with the services provided by each hospital to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits which may result in adjustments to the amounts ultimately determined to be due under these reimbursement programs. These audits often require several years to reach the final determination of amounts due. Providers have rights of appeal and it is common to contest issues raised in audits of prior years cost reports. Although the final outcome of these audits and the nature and amounts of any adjustments are difficult to predict, we believe that we have made adequate provisions in our financial statements for adjustments that may result from these audits and that final resolution of any contested issues should not have a material adverse effect upon our financial condition or results of operations. Until final adjustment, however, significant issues may remain unresolved and previously determined allowances could become either inadequate or greater than ultimately required.

In 2005, CMS began using recovery audit contractors (RACs) to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare claims filed by healthcare providers. The RAC program was made permanent by the Tax Relief and Health Care Act of 2006 will gradually roll-out in additional states. The Affordable Care Act expands the RAC program s scope to include managed Medicare and to include Medicaid claims beginning June 1, 2010, and by requiring all states to establish programs to contract with RACs in 2011. Currently all states where SunLink operates have RAC programs, and all SunLink facilities have had requests from the various RACs to review claims. To date since the commencement of the RAC program SunLink has experienced losses in the aggregate from audit adjustments of less than $10.

RACs perform post-discharge audits of medical records to identify Medicare overpayments resulting from incorrect payment amounts, non-covered services, incorrectly coded services, and duplicate services. CMS has given RACs the authority to look back at claims up to three years old, provided that the claim was paid on or after October 1, 2007. Claims review strategies used by RACs generally include a review of high dollar claims, including inpatient hospital claims. As a result, a large majority of the total amounts recovered by RACs has come from hospitals. Claims identified as overpayments will be subject to the Medicare appeals process.

RACs are paid a contingency fee based on the overpayments they identify and collect. We expect that the RACs will continue to look closely at claims submitted by our facilities in an attempt to identify possible overpayments. Although we believe the claims for reimbursement submitted to the Medicare program are accurate, we cannot predict the results of any future RAC audits.

In addition, CMS employs Medicaid Integrity Contractors (MICs) to perform post-payment audits of Medicaid claims and identify overpayments. The Affordable Care Act increases federal funding for the MIC program for federal fiscal year 2011 and later years. In addition to RACs and MICs, the state Medicaid agencies and other contractors have also increased their review activities.

If SunLink or any of our facilities were found to be in violation of Federal or state laws relating to Medicare, Medicaid or similar programs, the facility and SunLink could be subject to substantial monetary fines, civil penalties and exclusion from future participation in the Medicare and Medicaid programs. Any such sanctions could have a material adverse effect on our financial condition or results of operations.

Index to Financial Statements

SPECIALTY PHARMACY OPERATIONS

Our Specialty Pharmacy Segment is operated through our SunLink ScriptsRx, LLC subsidiary and is a pharmacy operations segment composed of four material service lines:

1. Specialty Pharmacy Services which ordinarily include one or more of the following elements:

   The provision of products relating to infusion therapy, enteral feeding services, oncology and chemotherapy drug administration, cardiac, diabetes, pain management, wound care, and psychiatric services;

   Pharmaceutical or biological products administered via non-oral means, which are frequently through injectable or infusion therapies;

   Products delivered to patients via express package or hand delivery and requiring special handling such as constant refrigeration or having an extremely limited shelf life;

   Products that generally are administered in a non-hospital setting, including physicians offices, specialty clinics or patient homes;

   The provision of pharmaceuticals or biological products not managed under traditional outpatient prescription drug benefits; and

   Therapies that require complex care, patient education and continuous monitoring.

The major conditions these drugs treat include, but are not limited to: respiratory system weakness, cancer, HIV/AIDS, hemophilia, hepatitis C, multiple sclerosis, infertility, Crohn s disease, rheumatoid arthritis, and growth hormone deficiency.

2. Institutional Pharmacy Services, consisting of the provision of specialty and non-specialty pharmaceuticals and biological products to institutional clients or to patients in institutional settings such as nursing homes, hospices, and correctional facilities;

3. Durable Medical Equipment Services, consisting primarily of products for patient-administered home care such as oxygen concentrators services, continuous positive airway pressure or CPAP machines, nebulizers, diabetes management products and prosthetics;

4. Retail Pharmacy Products and Services, consisting primarily of walk-in sales at our three distribution facilities in Louisiana of complementary products including uniforms, non-specialty pharmaceuticals, vitamins, supplements and nutritionals. We view our retail pharmacy operations as a source of incremental revenue to us while providing value added service to our patients in the form of full service pharmacy offerings.

Certain of the service lines in our Specialty Pharmacy Segment may overlap with our healthcare operations. Likewise, institutional pharmacy services may overlap with pharmacies in our healthcare facilities.

Government Reimbursement Programs

Our Specialty Pharmacy Business is subject to certain rules implemented by the Medicare Modernization Act (MMA) and, in the future may be subject to other rules previously implemented by MMA with respect to urban providers. Regulations implementing the cost containment mandates under the MMA reduced the reimbursement for healthcare providers in urban areas for a number of products and services which are also provided by our pharmacy operations and established a competitive bidding program for certain durable medical equipment provided under Medicare Part B in urban areas. Competitive bidding is intended to further reduce reimbursement for certain products and will likely decrease the number of companies permitted to serve Medicare beneficiaries in the competitive bidding areas (CBAs). CMS had planned to implement the competitive bidding program for Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) products and services with the goal of offering beneficiaries access to quality with lower

Index to Financial Statements

out-of-pocket costs. We were exempted under the Deficit Reduction Act of 2005 from the proposed competitive acquisition program for DMEPOS, but we cannot be sure such exemption will continue to be available in the future or that the program, if expanded in the future, would be expanded in its original form. If the program is expanded in the future, loss of the exemption could have an adverse effect on our financial condition or results of operation. The program has, however, been deferred indefinitely, and whether or not the program will be implemented in the future is unknown.

The MMA also created a Medicare prescription drug benefit (which began in 2006) and a prescription drug card program. Final rules implementing the portions of the MMA relating to the new prescription drug benefit were adopted in 2005.

Under MMA Medicare Part B covered drugs and biological products generally are paid based on the average sales price (ASP) methodology. The ASP methodology uses quarterly drug pricing data submitted to the CMS by drug manufacturers. CMS will supply contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Principal products paid under the ASP methodology include certain oncology and renal dialysis drugs. Although, there are exceptions to this general rule which are listed in the latest ASP quarterly change request (CR) document and which exceptions generally are paid on a cost basis, such exceptions have not been and are not expected to be material to our operations.

Beginning in January 2008, CMS s outpatient prospective payment system began paying for most separately payable Medicare Part B drugs administered in a hospital outpatient setting at a reimbursement level of ASP plus 5% and ASP plus 6% in other settings. Such outpatient price represented a decrease from ASP + 6%.

Section 303(d) of the MMA also requires the implementation of a competitive acquisition program (the Part B CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The Part B CAP is an alternative to the ASP methodology for acquiring certain Part B drugs which are administered incident to a physician s services. Currently, the Part B CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an approved Part B CAP vendor, thus reducing the time and cost of buying and billing for drugs. Currently, the CAP for Part B Drugs and Biologicals is only for injectable and infused drugs currently billed under Part B that are administered in a physician s office, incident to a physician s service.

In late 2005, CMS conducted the first round of bidding for approved Part B CAP vendors. The Part B CAP was implemented on July 1, 2006. The 2009-2011 CAP vendor bidding period concluded on February 15, 2008. CMS received several qualified bids; however, contractual issues with the successful bidders resulted in the 2009 program being postponed by CMS in September 2008. As a result, CAP drugs were not available from an approved CAP vendor for dates of service after December 31, 2008.

At least one Medicaid program has adopted, and other Medicaid programs, some states and some private payors may be expected to adopt, those aspects of the MMA that either result in or appear to result in price reductions for drugs covered by such programs. Adoption of ASP as the measure for determining reimbursement by Medicare and Medicaid programs for additional drugs sold by our specialty pharmacy operations could reduce revenue and gross margins and could materially affect our current average wholesale price (AWP) based reimbursement structure with private payors.

We cannot assure you that the ASP reimbursement methodology will not be extended to the provision of all specialty pharmaceuticals or to the specialty pharmaceuticals most often sold by our specialty pharmacy operations or that we will be able to operate our specialty pharmacy operations profitably at either existing or at lower reimbursement rates. Likewise, we cannot assure you that the Part B CAP program will not be extended to rural or exurban areas in general or to the areas in which we operate, or may seek to operate, in particular or that we would be able

to meet the qualifications to become a Part B CAP vendor either now or at any time in the future.

Index to Financial Statements

Competition

There are many companies which provide one or more of the healthcare operations which comprise or may compete with our pharmacy operations. For example, home healthcare business companies, which may compete with our specialty pharmacy services, our durable medical equipment services operations or both, range in size from small entrepreneurial companies to rapidly expanding companies with strategies for national operations such as Amedisys, Inc., Apria Healthcare Group, Inc., Gentiva Health Services, Inc., and Walgreen Co. Specialty pharmacy companies range from local or regional pharmacies to large public companies such as Option Care, Inc., a subsidiary of Walgreen Co., CVS Caremark Corporation, Priority Healthcare Corporation and BioScrip, Inc. Institutional pharmacy companies likewise range from local or regional pharmacies to large public companies including PharMerica Corporation and Omnicare, Inc.

Healthcare Regulation

Overview

The healthcare industry is one of the largest industries in the United States and continues to attract much legislative interest and public attention. There are many factors that are highly significant to the healthcare industry including Medicare, Medicaid, and other public and private hospital cost-containment programs, proposals to limit healthcare spending and proposals to limit prices and increase industry competition. The healthcare industry is governed by an extremely complex framework of Federal, state and local laws, rules and regulations.

There continue to be Federal and state proposals that would, and actions that do, impose limitations on government and private payments to providers, including community hospitals. In addition, there regularly are proposals to increase co-payments and deductibles from program and private patients. Hospital facilities also are affected by controls imposed by government and private payors designed to reduce admissions and lengths of stay. Such controls include what is commonly referred to as utilization review . Utilization review entails the review of a patient s admission and course of treatment by a third party. Historically, utilization review has resulted in a decrease in certain treatments and procedures being performed. Utilization review is required in connection with the provision of care which is to be funded by Medicare and Medicaid and is also required under many managed care arrangements.

Many states have enacted, or are considering enacting, additional measures that are designed to reduce their Medicaid expenditures and to make changes to private healthcare insurance. Various states have applied, or are considering applying, for a waiver from current Medicaid regulations in order to allow them to serve some of their Medicaid participants through managed care providers. These proposals also may attempt to include coverage for some people who presently are uninsured, and generally could have the effect of reducing payments to hospitals, physicians and other providers for the same level of service provided under Medicaid.

Healthcare Facility Regulation

Certificate of Need Requirements

A number of states require approval for the purchase, construction and expansion of various healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates of Need (CONs), which are issued by governmental agencies with jurisdiction over applicable healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or the addition of services and certain other matters. All three states in which SunLink currently operates hospitals (Georgia, Mississippi and Missouri) have CON laws that apply to such facilities. The two states (Georgia and Mississippi) in which SunLink currently operates nursing homes/skilled nursing facilities also have CON laws that apply to nursing homes and other skilled nursing facilities. States periodically review, modify and revise their CON laws and related regulations.

Index to Financial Statements

In addition, future healthcare facility acquisitions also may occur in states that require CONs. SunLink is unable to predict whether its healthcare facilities will be able to obtain any CONs that may be necessary to accomplish their business objectives in any jurisdiction where such certificates of need are required. Violation of these state laws may result in the imposition of civil sanctions or the revocation of licenses for such facilities.

Future healthcare facility acquisitions also may occur in states that do not require CONs or which have less stringent CON requirements than the states in which SunLink currently operates healthcare facilities. Any healthcare facility operated by SunLink in such states may face increased competition from new or expanding facilities operated by competitors, including physicians.

Utilization Review Compliance and Hospital Governance

SunLink s healthcare facilities are subject to, and comply with, various forms of utilization review. In addition, under the Medicare prospective payment system, each state must have a peer review organization to carry out a federally mandated system of review of Medicare patient admissions, treatments and discharges in hospitals. Medical and surgical services and physician practices are supervised by committees of staff doctors at each healthcare facility; are overseen by each healthcare facility s local governing board, the primary voting members of which are physicians and community members; and are reviewed by SunLink s quality assurance personnel. The local governing boards also help maintain standards for quality care, develop long-range plans, establish, review and enforce practices and procedures and approve the credentials and disciplining of medical staff members.

Emergency Medical Treatment and Active Labor Act

All of our facilities are subject to the Emergency Medical Treatment and Active Labor Act (EMTALA). This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents himself to the hospital s emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient s ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer a patient or if the hospital delays appropriate treatment in order to first inquire about the patient s ability to pay. Penalties for violations of EMTALA include civil monetary penalties and exclusion from participation in the Medicare program, the Medicaid program or both. In addition, an injured patient, the patient s family or a medical facility that suffers a financial loss as a direct result of another hospital s violation of the law can bring a civil suit against that other hospital. Although we believe that our hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and whether we will be able to comply with any new requirements.

Conversion Legislation

Many states, including some where we have hospitals and others where we may in the future acquire hospitals, have adopted legislation regarding the sale or other disposition of hospitals operated by not-for-profit entities. In other states that do not have specific legislation, state attorneys generally have demonstrated an interest in these transactions under their general obligations to protect charitable assets from waste. These legislative and administrative efforts primarily focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the not-for-profit seller. These reviews and, in some instances, approval processes, can add additional time to the closing of a hospital acquisition. There can be no assurance that future actions on the state level will not seriously delay or even prevent our ability to acquire hospitals. If these activities are widespread, they could limit our ability to acquire additional hospitals or increase our acquisition costs.

23

Index to Financial Statements

Specialty Pharmacy Segment Regulation

Overview

Much like our healthcare facility operations, the operations of our Specialty Pharmacy Segment are subject to various Federal and state statutes and regulations governing their operations including laws and regulations with respect to operation of pharmacies, repackaging of drug products, wholesale distribution, dispensing of controlled substances, cross jurisdictional sale and distribution of pharmacy products, medical waste disposal, clinical trials and non-discriminatory access. Federal statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs as well as the dispensing of controlled substances. Federal controlled substance laws require us to register our pharmacies and repackaging facilities with the United States Drug Enforcement Administration (DEA) and to comply with security, recordkeeping, inventory control and labeling standards in order to dispense controlled substances. Although we believe that the operations of our Specialty Pharmacy Segment have obtained the permits and/or licenses required to conduct our specialty pharmacy business as currently conducted, a failure to have the necessary permits and licenses could have a material adverse effect on our specialty pharmacy business, and our financial condition or results of operations.

Mail Order Activities

Currently the activities of our hospital pharmacies are ancillary to the operations of the facilities they serve. In contrast, the operations of our specialty pharmacy services operations are stand-alone operations that, in addition to walk-in customers, distribute pharmaceuticals through a variety of delivery methods, including by mail and express delivery services. Many states in which we deliver or may seek to deliver pharmaceuticals have laws and regulations that require out-of-state mail service pharmacies to register with, or be licensed by, the boards of pharmacy or similar regulatory bodies in those states. These states generally permit the dispensing pharmacy to follow the laws of the state within which the dispensing pharmacy is located.

However, various state Medicaid programs have enacted laws and/or adopted rules or regulations directed at restricting or prohibiting the operation of out-of-state pharmacies by, among other things, requiring compliance with all laws of the states into which the out-of-state pharmacy dispenses medications, whether or not those laws conflict with the laws of the state in which the pharmacy is located, or requiring the pharmacist-in-charge to be licensed in that state. To the extent that such laws or regulations are found to be applicable to our operations, we believe our specialty pharmacy operations comply with them in all material respects. To the extent that any of the foregoing laws or regulations prohibit or restrict the operation of mail service pharmacies and are found to be applicable to our specialty pharmacy operations, they could have an adverse effect on our ability to expand our pharmacy operations, which currently are concentrated in Louisiana. A number of state Medicaid programs prohibit the participation in such state s Medicare program by either out-of-state retail pharmacies or mail order pharmacies, whether located in-state or out-of-state.

Advertising and Marketing Regulations

There are also other statutes and regulations which may affect advertising, marketing and distribution of pharmacy products by our specialty pharmacy services. The Federal Trade Commission requires mail order sellers of goods generally to engage in truthful advertising, to stock a reasonable supply of the products to be sold, to fill mail orders within 30 days, and to provide clients with refunds when appropriate.

Healthcare Regulations of General Application

Licensing Requirements

SunLink s healthcare operations are subject to extensive Federal, state and local licensing requirements. In order to maintain their operating licenses, our healthcare facility operations must comply with strict standards concerning medical care, equipment and hygiene. Various licenses and permits also are required in order to

Index to Financial Statements

handle radioactive materials and operate certain equipment. All licenses, provider numbers, and other permits or approvals required to perform our business operations are held by individual subsidiaries of SunLink. Each of our hospital operating subsidiaries operates only a single hospital. All of SunLink s hospitals, except the leased hospital in Dexter, Missouri, are fully accredited by the JCAHO.

Drugs and Controlled Substances

Various licenses and permits are required by our healthcare facilities and specialty pharmacy business in order to dispense narcotics and operate pharmacies. We are required to register our pharmacy operations for permits and/or licenses with, and comply with certain operating and security standards of, the United States DEA, the Food and Drug Administration, or FDA, State Boards of Pharmacy, state health departments and other state agencies in states where we operate or may seek to operate.

State controlled substance laws require registration and compliance with state pharmacy licensure, registration or permit standards promulgated by the state s pharmacy licensing authority. Such standards often address the qualification of an applicant s personnel, the adequacy of its prescription fulfillment and inventory control practices and the adequacy of its facilities. In general, pharmacy licenses are renewed annually. Pharmacists and pharmacy technicians employed at each of our dispensing locations must also satisfy applicable state licensing requirements.

Fraud and Abuse, Anti-Kickback and Self-Referral Regulations

Participation in the Medicare and/or Medicaid programs is heavily regulated by federal statutes and regulations. If a hospital fails to comply substantially with the numerous federal laws governing a facility s activities, the hospital s participation in the Medicare and/or Medicaid programs may be terminated and/or civil or criminal penalties may be imposed. For example, a hospital may lose its ability to participate in the Medicare and/or Medicaid programs if it:

- makes claims to Medicare and/or Medicaid for services not provided or misrepresents actual services provided in order to obtain higher payments;
- pays money to induce the referral of patients or the purchase of items or services where such items or services are reimbursable under a Federal or state health program;
- fails to report or repay; or
- fails to provide appropriate emergency medical screening services to any individual who comes to a hospital s campus or otherwise fails to properly treat and transfer emergency patients.

Hospitals continue to be one of the primary focus areas of the OIG and other governmental fraud and abuse programs. In January 2005, the OIG issued Supplemental Compliance Program Guidance for Hospitals that focuses on hospital compliance risk areas. Some of the risk areas highlighted by the OIG include correct outpatient procedure coding, revising admission and discharge policies to reflect current CMS rules, submitting appropriate claims for supplemental payments such as pass-through costs and outlier payments and a general discussion of the fraud and abuse risks related to financial relationships with referral sources. Each federal fiscal year, the OIG also publishes a General Work Plan that provides a brief description of the activities that the OIG plans to initiate or continue with respect to the programs and operations of the

Department of Health and Human Services (HHS) and details the areas that the OIG believes are prone to fraud and abuse.

Sections of the Anti-Fraud and Abuse Amendments to the Social Security Act, commonly known as the anti-kickback statute, prohibit certain business practices and relationships that might influence the provision and cost of healthcare services reimbursable under Medicare, Medicaid, TriCare or other healthcare programs, including the payment or receipt of remuneration for the referral of patients whose care will be funded by Medicare or other government programs. Sanctions for violating the anti-kickback statute include criminal penalties and civil sanctions, including fines and possible exclusion from future participation in government

Index to Financial Statements

programs, such as Medicare and Medicaid. Pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, the U.S. Department of Health and Human Services (DHHS) issued regulations that create safe harbors under the anti-kickback statute. A given business arrangement that does not fall within an enumerated safe harbor is not *per se* illegal; however, business arrangements that fail to satisfy the applicable safe harbor criteria are subject to increased scrutiny by enforcement authorities.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) broadened the scope of the fraud and abuse laws by adding several criminal statutes that are not related to receipt of payments from a federal healthcare program. HIPAA created civil penalties for proscribed conduct, including upcoding and billing for medically unnecessary goods or services. These laws cover all health insurance programs, private as well as governmental. In addition, HIPAA broadened the scope of certain fraud and abuse laws, such as the anti-kickback statute, to include not just Medicare and Medicaid services, but all healthcare services reimbursed under a Federal or state healthcare program. Finally, HIPAA established enforcement mechanisms to combat fraud and abuse. These mechanisms include a bounty system where a portion of the payment recovered is returned to the government agencies, as well as a whistleblower program, where a portion of the payment received is paid to the whistleblower. HIPAA also expanded the categories of persons that may be excluded from participation in Federal and state healthcare programs.

There is increasing scrutiny by law enforcement authorities, the Office of Inspector General of the DHHS, the courts and the U.S. Congress of arrangements between healthcare providers and potential referral sources to ensure that the arrangements are not designed as mechanisms to exchange remuneration for patient-care referrals and opportunities. Investigators also have demonstrated a willingness to look behind the formalities of a business transaction to determine the underlying purpose of payments between healthcare providers and potential referral sources. Enforcement actions have increased, as is evidenced by highly publicized enforcement investigations of certain hospital activities.

In addition, provisions of the Social Security Act, known as the Stark Act, also prohibit physicians from referring Medicare and Medicaid patients to providers of a broad range of designated health services with which the physicians or their immediate family members have ownership or certain other financial arrangements. Certain exceptions are available for employment agreements, leases, physician recruitment and certain other physician arrangements. A person making a referral, or seeking payment for services referred, in violation of the Stark Act is subject to civil monetary penalties of up to $15 for each service; restitution of any amounts received for illegally billed claims; and/or exclusion from future participation in the Medicare program, which can subject the person or entity to exclusion from future participation in state healthcare programs.

Further, if any physician or entity enters into an arrangement or scheme that the physician or entity knows or should have known has the principal purpose of assuring referrals by the physician to a particular entity, and the physician directly makes referrals to such entity, then such physician or entity could be subject to a civil monetary penalty of up to $100. In addition, the monitoring of compliance with and the enforcing of penalties for violations of these laws and regulations is changing and increasing. For example, in 2010, CMS issued a self-referral disclosure protocol for hospitals and other providers that wish to self-disclose potential violations of the Stark Act and attempt to resolve those potential violations and any related overpayment liabilities at levels below the maximum penalties and amounts set forth in the statute. In light of the provisions of the Affordable Care Act that created potential liabilities under the federal False Claims Act (discussed below) for failing to report and repay known overpayments and return an overpayment within sixty (60) days of the identification of the overpayment or the date by which a corresponding cost report is due, whichever is later, hospitals and other healthcare providers are encouraged to disclose potential violations of the Stark Act to CMS. It is likely that self-disclosure of Stark violations will continue in the future. Finally, many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care.

Index to Financial Statements

The Federal False Claims Act and Similar State Laws

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government. The federal False Claims Act defines the term knowingly broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the knowing submission of a false or fraudulent claim for the purposes of the False Claims Act. The qui tam or whistleblower provisions of the False Claims Act allow private individuals to bring actions under the False Claims Act on behalf of the government. These private parties are entitled to share in any amounts recovered by the government, and, as a result, the number of whistleblower lawsuits that have been filed against providers has increased significantly in recent years. When a private party brings a qui tam action under the federal False Claims Act, the defendant will generally not be aware of the lawsuit until the government makes a determination whether it will intervene and take a lead in the litigation. If a provider is found to be liable under the federal False Claims Act, the provider may be required to pay up to three times the actual damages sustained by the government plus mandatory civil monetary penalties of between $5 to $11 for each separate false claim. The government has used the federal False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, submitting false cost reports, and providing care that is not medically necessary or that is substandard in quality.

HIPAA Transaction, Privacy and Security Requirements

HIPAA and federal regulations issued pursuant to HIPAA contain, among other measures, provisions that have required us to implement modified or new computer systems, employee training programs and business procedures. The federal regulations are intended to encourage electronic commerce in the healthcare industry, provide for the confidentiality and privacy of patient healthcare information and ensure the security of healthcare information.

A violation of the HIPAA regulations could result in civil money penalties of $1 per incident, up to a maximum of $25 per person, per year, per standard violated. HIPAA also provides for criminal penalties of up to $50 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to $100 and five years in prison for obtaining protected health information under false pretenses and up to $250 and ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Since there is no significant history of enforcement efforts by the Federal government at this time, it is not possible to ascertain the likelihood of enforcement efforts in connection with the HIPAA regulations or the potential for fines and penalties, which may result from any violation of the regulations.

HIPAA Privacy Regulations

HIPAA privacy regulations protect the privacy of individually identifiable health information. The regulations provide increased patient control over medical records, mandate substantial financial penalties for violation of a patient s right to privacy and, with a few exceptions, require that an individual s individually identifiable health information only be used for healthcare-related purposes. These privacy standards apply to all health plans, all healthcare clearinghouses and healthcare providers, such as our facilities, that transmit health information in an electronic form in connection with standard transactions, and apply to individually identifiable information held or disclosed by a covered entity in any form. These standards impose extensive administrative requirements on our facilities and require compliance with rules governing the use and disclosure of such health information, and they require our facilities to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on behalf of our facilities. In addition, our facilities are subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary by state and could impose stricter standards and additional penalties.

27

Index to Financial Statements

The HIPAA privacy regulations also require healthcare providers to implement and enforce privacy policies to ensure compliance with the regulations and standards. Under the direction of SunLink s Vice President, Technical and Compliance Services, and in conjunction with a private HIPAA consultant and HIPAA coordinators at each facility, individually tailored policies and procedures were developed and implemented and HIPAA privacy educational programs were presented to all employees and physicians at each facility prior to the compliance deadline. We believe we are in compliance with current HIPAA privacy regulations.

HIPAA Electronic Data Standards

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for all healthcare related electronic data interchange. These provisions are intended to streamline and encourage electronic commerce in the healthcare industry. Among other things, these provisions require healthcare facilities to use standard data formats and code sets established by the DHHS when electronically transmitting information in connection with certain transactions, including health claims and equivalent encounter information, healthcare payment and remittance advice and health claim status.

The DHHS regulations establish electronic data transmission standards that all healthcare providers and payors must use when submitting and receiving certain electronic healthcare transactions. The uniform data transmission standards are designed to enable healthcare providers to exchange billing and payment information directly with the many payors thereby eliminating data clearinghouses and simplifying the interface programs necessary to perform this function. We believe that the management information systems at our facilities and at our corporate headquarters comply with HIPAA s electronic data regulations and standards.

HIPAA Security Standards

The Administrative Simplification Provisions of HIPAA require the use of a series of security standards for the protection of electronic health information. The HIPAA security standards rule specifies a series of administrative, technical and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. The standards are delineated into either required or addressable implementation specifications.

Under the direction of SunLink s Vice President, Technical and Compliance Services, and in conjunction with a consortium of rural hospitals, private HIPAA security consultants and HIPAA security officers at each facility, we have performed security assessments, and implemented individually tailored plans to apply required or addressable solutions and implemented a set of security policies and procedures. In addition, we developed and adopted an individually tailored comprehensive disaster contingency plan for each facility and presented a HIPAA security training program to all applicable personnel. SunLink believes it is in full compliance with all aspects of the HIPAA security regulations.

HIPAA National Provider Identifier

HIPAA also required DHHS to issue regulations establishing standard unique health identifiers for individuals, employers, health plans and healthcare providers to be used in connection with standard electronic transactions. All healthcare providers, including our facilities, were required to obtain a new National Provider Identifier (NPI) to be used in standard transactions instead of other numerical identifiers by May 23, 2007. Our facilities have fully implemented use of a standard unique healthcare identifier by utilizing their employer identification number. DHHS has not yet issued proposed rules that establish the standard for unique health identifiers for health plans or individuals. Once these

regulations are issued in final form, we expect to have approximately one to two years to become fully compliant, but cannot predict the impact of such changes at this time. We cannot predict whether our facilities may experience payment delays during the transition to the new identifiers. DHHS is currently working on the standards for identifiers for health plans; however, there are currently no proposed timelines for issuance of proposed or final rules. The issuance of proposed rules for individuals is on hold indefinitely.

Index to Financial Statements

Medical Waste Regulations

Our operations, especially our healthcare facility operations, generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations are also generally subject to various other environmental laws, rules and regulations. Such compliance costs are not significant and we do not anticipate that such compliance costs will be significant in the future.

SUNLINK OPERATIONS

Regulatory Compliance Program

SunLink maintains a company-wide compliance program under the direction of the Director of Reimbursement and Compliance. SunLink s compliance program is directed at all areas of regulatory compliance, including physician recruitment, reimbursement and cost reporting practices, as well as pharmacy and home healthcare operations. Each hospital designates a compliance officer and develops plans to correct problems should they arise. In addition, all employees are provided with a copy of and given an introduction to SunLink s *Code of Conduct*, which includes ethical and compliance guidelines and instructions about the proper resources to utilize in order to address any concerns that may arise. Each hospital conducts annual training to re-emphasize SunLink s *Code of Conduct*. We monitor our corporate compliance program to respond to developments in healthcare regulations and the industry. SunLink also maintains a toll-free hotline to permit employees to report compliance concerns on an anonymous basis.

Professional Liability

As part of our business, we are subject to claims of liability for events occurring in the ordinary course of operations. To cover a portion of these claims, we maintain professional malpractice liability insurance and general liability insurance in amounts, which are commercially available, that we believe are sufficient for our operations, although some claims may exceed the scope or amount of the coverage in effect.

In connection with the acquisition of our initial six community hospitals, SunLink assumed responsibility for general and professional liability claims reported after February 1, 2001 (our acquisition date of such hospitals), and the previous owner retained responsibility for all known and filed claims. We have purchased claims-made commercial insurance (with a substantial self-insured retention) for coverage prior to and after the acquisition date. The recorded liability for general and professional liability risks includes an estimate of the liability for claims incurred prior to February 1, 2001, but reported after February 1, 2001 and for claims incurred after February 1, 2001. In connection with the acquisition of HealthMont and its two hospitals, SunLink assumed responsibility for all professional liability claims. HealthMont had purchased claims-made commercial insurance for claims made prior to the acquisition. The recorded liability for professional liability risks includes an estimate of liability for claims assumed at the acquisition and for claims incurred after the acquisition. These estimates are based on actuarially determined amounts.

Environmental Regulation

We believe we are in substantial compliance with applicable federal, state and local environmental regulations. To date, compliance with federal, state and local laws regulating the discharge of material into the environment or otherwise relating to the protection of the environment have not had a material effect upon our consolidated results of operations, consolidated financial condition or competitive position. Similarly, we have not had to make material capital expenditures to comply with such regulations.

Index to Financial Statements

EXECUTIVE OFFICERS OF THE REGISTRANT

Our executive officers, as of September 15, 2011, their positions with the Company or its subsidiaries and their ages are as follows:

Name	Offices	Age
Robert M. Thornton, Jr.	Director, Chairman of the Board of Directors, President and Chief Executive Officer	62
Mark J. Stockslager	Chief Financial Officer and Principal Accounting Officer	52
A. Ronald Turner	Chief Operating Officer	65
Byron D. Finn	President SunLink ScriptsRx, LLC	61
Jack M. Spurr, Jr	Vice President, Hospital Financial Operations	66

All of our executive officers hold office for an indefinite term, subject to the discretion of the Board of Directors.

Robert M. Thornton, Jr. has been Chairman and Chief Executive Officer of SunLink Health Systems, Inc. since September 10, 1998, President since July 16, 1996 and was Chief Financial Officer from July 18, 1997 to August 31, 2002. From March 1995 to the present, Mr. Thornton has been a private investor in and Chairman and Chief Executive Officer of CareVest Capital, LLC, a private investment and management services firm. Mr. Thornton was President, Chief Operating Officer, Chief Financial Officer and a director of Hallmark Healthcare Corporation (Hallmark) from November 1993 until Hallmark s merger with Community Health Systems, Inc. in October 1994. From October 1987 until November 1993, Mr. Thornton was Executive Vice President, Chief Financial Officer, Secretary, Treasurer and a director of Hallmark.

Mark J. Stockslager has been Chief Financial Officer of SunLink Health Systems, Inc. since July 1, 2007. He was interim Chief Financial Office from November 6, 2006 until June 30, 2007. He has been the Principal Accounting Officer since March 11, 1998 and was Corporate Controller from November 6, 1996 to June 4, 2007. He has been associated continuously with our accounting and finance operations since June 1988 and has held various positions, including Manager of U.S. Accounting, from June 1993 until November 1996. From June 1982 through May 1988, Mr. Stockslager was employed by Price Waterhouse & Co.

A. Ronald Turner was named Chief Operating Officer of SunLink on November 30, 2010. Mr. Turner is an entrepreneur, experienced hospital management company executive and CPA who worked as an independent management consultant for sixteen months prior to joining SunLink. Mr. Turner co-founded Associated Healthcare Systems, Inc. and served as its President and CEO from April 1999 to December 2009. From July 1985 to April 1999, Mr. Turner was a private investor and management consultant who, among other things, led the merger, acquisition and financing activities for a number of hospital and other healthcare industry transactions. Mr. Turner served as the President and Chief Operating Officer of Health Group Inc. from August 1982 to July 1985. Mr. Turner co-founded Southern Health Services, Inc. and served as its President, Chief Operating Officer and a director from December 1978 to August 1982. Prior to December 1978, Mr. Turner practiced as a CPA in Arthur Young & Company s National Healthcare Group and with Ernst & Whinney.

Byron D. Finn was named President of SunLink ScriptsRx, LLC on October 1, 2010. Mr. Finn was most recently president of Byron D. Finn, CPA, PC, which provided accounting, financial consulting and litigation support services to its clients, including numerous healthcare clients. His experience also includes various positions with The Coca-Cola Company, where he served in a number of financial-related positions and in connection with special projects, and he was previously employed by Ernst & Young. Mr. Finn is a licensed CPA and received his BA in Business Administration and Master in Accountancy degrees from the University of Georgia.

Jack M. Spurr, Jr. has been Vice President, Hospital Financial Operations for the Company since October 1, 2002. From February 1, 2001 until September 30, 2002, Mr. Spurr performed several interim financial roles for

Index to Financial Statements

the Company. From 1978 to 2000, Mr. Spurr held financial positions with Hospital Corporation of America, Columbia Healthcare, Inc., Quorum Health Group, Inc., HealthTrust, Inc., and National Healthcare Inc.

Item 1A. ***Risk Factors***

In addition to other information contained in this Annual Report, including certain cautionary and forward-looking statements, you should carefully consider the following factors in evaluating an investment in SunLink:

Consolidated Operations Risks

We may not be able to obtain a replacement for our existing Credit Facility. SunLink s primary credit agreement has been modified three times in the past year, with the latest modification dated July 28, 2011 (July 2011 Modification). The termination date of the Credit Facility was changed from September 30, 2011 to January 1, 2013. Although SunLink was not in compliance with certain of the financial covenants contained in the Credit Facility at June 30, 2011, the Credit Facility was subsequently amended by the July 2011 Modification to change the affected covenants so as to bring us into compliance.

We are seeking to refinance the Credit Facility with a new lender and reduced borrowing under the Term Loan of the Credit Facility by approximately $10,000. Although, we believe the Company will be able to refinance existing borrowings under one or more replacement loan facilities either on a company wide or individual facility basis, there can be no assurance that we will be able to obtain new financing in the amount needed, on improved or comparable terms, or at all. We believe that the Company should be able to continue in compliance with the financial covenants in our Credit Facility as amended, but there is also no assurance that we will be able to do so. Our ability to make the required debt service and increased interest payments under the Credit Facility depends on, among other things, our ability to generate sufficient cash flows from operating activities. If we are unable to generate sufficient cash flow from operations to meet our debt service commitments or are unable to refinance or restructure our indebtedness prior to maturity at January 1, 2013, such failure could have material adverse effects on the Company.

If our operating results continue to decline, we may not be able to generate sufficient cash flows to meet our liquidity needs.

We rely upon cash on hand, cash from operations and a revolving loan facility to fund our cash requirements for working capital, capital expenditures, commitments and payments of principal and interest on borrowings. Our ability to generate cash from operations has been negatively impacted by uncollectible self-pay net revenues of our Healthcare Facilities Segment, increased salaries expenses for employed physicians and decreased patient volume at our facilities as a result of economic conditions in the locations we serve as well as decreased sales volume and earning experienced by our Specialty Pharmacy Segment. We expect that these factors will continue to have a negative impact on our business for the foreseeable future. Further deterioration would negatively impact our results of operations and cash flows.

We may not be able to maintain compliance with or borrow under out existing Credit Facility.

We currently have borrowing capacity under the revolving portion of the Credit Facility but there can be no assurance that we will be in compliance with the financial covenants. If non-compliance occurs, we may have no ability to borrow funds under the revolving portion of the

Credit Facility. If we are unable to borrow under our existing Credit Facility or obtain alternative financing such failure could have a material adverse effect on the Company.

Index to Financial Statements

Additional debt or equity capital for significant capital investments may be required to achieve SunLink s operational and growth plans, the inability to access capital may affect SunLink s competitive position, reduce earnings, and negatively affect the value of your SunLink common stock.

SunLink s operational and growth plans require significant capital investments. Significant capital investments are required for on-going and planned capital improvements at existing hospitals and may be required in connection with future capital projects either in connection with existing properties or future acquired properties. SunLink s ability to make capital investments depends on numerous factors such as the availability of funds from operations and its credit facility and access to additional debt and equity financing. No assurance can be given that the necessary funds will be available. Moreover, incurrence of additional debt financing, if available, may involve additional restrictive covenants that could negatively affect SunLink s ability to operate its business in the desired manner, and raising additional equity may be dilutive to shareholders. The failure to obtain funds necessary for the realization of SunLink s plans could prevent SunLink from realizing its strategies and, in particular, could force SunLink to forego opportunities that may arise in the future. This could, in turn, have a negative impact on SunLink s competitive position.

SunLink s revenues are heavily concentrated in Georgia which makes SunLink particularly sensitive to economic and other changes in the state of Georgia.

For the fiscal year ended June 30, 2011, our three Georgia hospitals generated approximately 57% of consolidated gross revenues for the year. Accordingly, any adverse change in the current demographic, economic, competitive or regulatory conditions in the state of Georgia could have a material adverse effect on the business, financial condition, results of operations or prospects of SunLink.

SunLink depends heavily on its management personnel and the loss of the services of one or more of SunLink s key senior management personnel could weaken SunLink s management team.

SunLink has been, and will continue to be, dependent upon the services and management experience of its executive officers. If any of SunLink s executive officers were to resign their positions or otherwise be unable to serve, SunLink s management could be weakened and operating results could be adversely affected; however, to our knowledge, no key executive personnel intend to retire or terminate their employment with SunLink in the near future.

SunLink conducts business in a heavily regulated industry; changes in regulations or violations of regulations may result in increased costs or sanctions that could reduce revenue and profitability.

The healthcare industry is subject to extensive Federal, state and local laws and regulations relating to:

- licensure;
- conduct of operations including patient referrals, physician recruiting practices, cost reporting and billing practices;

ownership of facilities;

addition of facilities and services;

confidentiality, maintenance, and security issues associated with medical records;

billing for services; and

prices for services.

These laws and regulations are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations, including in particular, Medicare and Medicaid anti-fraud and abuse amendments, codified in Section 1128B(b) of the Social Security

Index to Financial Statements

Act and known as the anti-kickback statute. This law prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid, and other Federal healthcare programs.

DHHS regulations describe some of the conduct and business relationships immune from prosecution under the anti-kickback statute. The fact that a given business arrangement does not fall within one of these safe harbor provisions does not render the arrangement illegal. However, business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria risk increased scrutiny by enforcement authorities.

We have a variety of financial relationships with physicians who refer patients to our hospitals. We have contracts with physicians providing services under a variety of financial arrangements such as employment contracts and professional service agreements. We also provide financial incentives, including loans and minimum revenue guarantees, to recruit physicians into the communities served by our hospitals.

HIPAA broadened the scope of the fraud and abuse laws to include all healthcare services, whether or not they are reimbursed under a Federal program. In addition, provisions of the Social Security Act, known as the Stark Act, also prohibit physicians from referring Medicare and Medicaid patients to providers of a broad range of designated health services in which the physicians or their immediate family members have an ownership interest or certain other financial arrangements.

In addition, SunLink s facilities will continue to remain subject to any state laws that are more restrictive than the regulations issued under HIPAA, which vary by state and could impose additional penalties. In recent years, both Federal and state government agencies have announced plans for or implemented heightened and coordinated civil and criminal enforcement efforts.

Government officials charged with responsibility for enforcing healthcare laws could assert that SunLink or any of the transactions in which the Company or its subsidiaries or their predecessors is or was involved, are in violation of these laws. It is also possible that these laws ultimately could be interpreted by the courts in a manner that is different from the interpretations made by the Company or others. A determination that either SunLink or its subsidiaries or their predecessors is or was involved in a transaction that violated these laws, or the public announcement that SunLink or its subsidiaries or their predecessors is being investigated for possible violations of these laws, could have a material adverse effect on SunLink s business, financial condition, results of operations or prospects and SunLink s business reputation could suffer significantly.

The laws, rules, and regulations described above are complex and subject to interpretation. In the event of a determination that we are in violation of any of these laws, rules or regulations, or if further changes in the regulatory framework occur, our results of operations could be significantly harmed.

SunLink is and in the future could be subject to claims related to discontinued operations, hospitals sold by our HealthMont subsidiary prior to its acquisition, and claims related to the disposition of our former Mountainside Medical Center.

Over the past 22 years, SunLink has discontinued operations carried on by its former industrial and life sciences and engineering segments, and U.K. child safety segments, leisure marine, and housewares segments and its former Mountainside Medical Center (by virtue of the sale of such facility whose original facility was one of our original hospitals). Prior to our acquisition of our HealthMont subsidiaries, HealthMont had sold two hospitals and it also disposed of one additional hospital as a condition to our acquisition of HealthMont. Contingent obligations related to

discontinued operations include guarantees of certain obligations of former subsidiaries. SunLink currently does not purchase insurance policies to reduce product liability or other discontinued operations exposures and does not anticipate it will purchase such insurance in the future. Based upon an evaluation of information currently available and consultation with legal counsel, management has not reserved any amounts for contingencies related to the discontinued operations.

Index to Financial Statements

The industry trend towards value-based purchasing may negatively impact our revenues.

There is a trend in the healthcare industry toward value-based purchasing of healthcare services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare and Medicaid currently require hospitals to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events. Many large commercial payors currently require hospitals to report quality data, and several commercial payors do not reimburse hospitals for certain preventable adverse events.

The Affordable Care Act contains a number of provisions intended to promote value-based purchasing. Effective July 1, 2011, the Affordable Care Act will prohibit the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat hospital acquired conditions (**HACs**). An HAC is a condition that is acquired by a patient while admitted as an inpatient at a hospital, such as a surgical site infection. Beginning in federal fiscal year 2015, hospitals that fall into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Hospitals with excessive readmissions for conditions designated by HHS will receive reduced payments for all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard.

The Affordable Care Act also requires DHHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires DHHS to reduce inpatient hospital payments for all discharges by a percentage beginning at 1% in federal fiscal year 2013 and increasing by 0.25% each fiscal year up to 2% in federal fiscal year 2017 and subsequent years. DHHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by DHHS. DHHS will determine the amount each hospital that meets or exceeds the quality performance standards will receive from the pool of dollars created by these payment reductions.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. We are unable at this time to predict how this trend will affect our results of operations, but it could negatively impact our financial condition or results of operations.

The lingering effects of the economic recession could materially adversely affect our cash flows, financial position, or results of operations.

The United States economy recently experienced a major economic recession, the economy remains weak, unemployment levels remain high, and there is a substantial risk that the economy will lapse back into recession. While certain healthcare spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of healthcare spending may be adversely impacted by such conditions. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose:

- to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals; or
- a high-deductible insurance plan or no insurance at all, which increases a hospital s dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

We believe the economic recession has had an adverse effect on our business. Furthermore, although we are unable to predict the specific impact of continued adverse economic conditions on our business, we believe that the lingering effects of the economic recession could have an adverse impact on our operations and could impact not only the healthcare decisions of our patients, but also the solvency of managed care providers and other counterparties to transactions with us.

Index to Financial Statements

SunLink is subject to potential claims for professional liability, including claims based on the acts or omissions of third parties, which claims may not be covered by insurance.

SunLink is subject to potential claims for professional liability (medical malpractice), both in connection with our current operations, as well as acquired operations. To cover these claims, we maintain professional malpractice liability insurance and general liability insurance in amounts that we believe are sufficient for our operations, although some claims may exceed the scope or amount of the coverage in effect. The assertion of a significant number of claims, either within our self-insured retention (deductible) or individually or in the aggregate in excess of available insurance, could have a material adverse effect on our results of operations or financial condition. Premiums for professional liability insurance have historically been volatile and we cannot assure you that professional liability insurance will continue to be available on terms acceptable to us, if at all. The operations of our hospitals also depend on the professional services of physicians and other trained healthcare providers and technicians in the conduct of their respective operations, including independent laboratories and physicians rendering diagnostic and medical services. There can be no assurance that any legal action stemming from the act or omission of a third party provider of healthcare services, would not be brought against one of our hospitals or SunLink, resulting in significant legal expenses in order to defend against such legal action or to obtain a financial contribution from the third-party whose acts or omissions occasioned the legal action.

Risks Related to Our Healthcare Facility Operations

SunLink s success depends on its ability to maintain good relationships with the physicians at its hospitals and, if SunLink is unable to successfully maintain good relationships with physicians, admissions and outpatient revenues at SunLink hospitals may decrease and SunLink s operating performance could decline.

Because physicians generally direct the majority of hospital admissions and outpatient services, SunLink s success is, in part, dependent upon the number and quality of physicians on the medical staffs of its hospitals, the admissions and referrals practices of the physicians at our hospitals, and our ability to maintain good relations with our physicians. Many physicians at SunLink hospitals are not employees of the hospitals at which they practice and, in many of the markets that SunLink serves, most physicians have admitting privileges at other hospitals in addition to SunLink s hospitals. If SunLink is unable to successfully maintain good relationships with physicians, admissions at SunLink hospitals may decrease and SunLink s operating performance could decline.

SunLink depends heavily on its healthcare facility management personnel and the loss of the services of one or more of SunLink s key local management personnel could weaken SunLink s management team and its ability to deliver healthcare services.

SunLink s success depends on its ability to attract and retain managers at its hospitals and related health care facilities, on the ability of hospital-based officers and key employees to manage growth successfully, and on their ability to attract and retain skilled employees. SunLink has not had any material difficulties in attracting healthcare facility management; however, if SunLink is unable to attract and retain affective local management, the operating performance of our facilities could decline.

SunLink s success depends on its ability to attract and retain qualified healthcare professionals and a shortage of qualified healthcare professionals in certain markets could weaken our ability to deliver healthcare services.

In addition to the physicians and management personnel whom SunLink employs, SunLink s operations are dependent on the efforts, ability, and experience of other healthcare professionals, such as nurses, pharmacists and lab technicians. Nurses, pharmacists, lab technicians and other healthcare professionals are generally employees of each individual SunLink hospital. SunLink s success has been, and will continue to be, influenced

Index to Financial Statements

by its ability to attract and retain these skilled employees. A shortage of healthcare professionals in certain markets, the loss of some or all of its key employees or the inability to attract or retain sufficient numbers of qualified healthcare professionals could cause SunLink s operating performance to decline.

A significant portion of SunLink s revenue is dependent on Medicare and Medicaid payments, and possible reductions in Medicare or Medicaid payments or the implementation of other measures to reduce reimbursements may reduce our revenues.

A significant portion of SunLink s revenues are derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. SunLink derived approximately 82% of its patient days and 57% of its net patient revenues from the Medicare and Medicaid programs for the year ended June 30, 2011. Previous legislative changes have resulted in, and future legislative changes may result in, limitations on and reduced levels of payment and reimbursement for a substantial portion of hospital procedures and costs.

Future healthcare legislation or other changes in the administration or interpretation of governmental healthcare programs may have a material adverse effect on SunLink s business, financial condition, results of operations or prospects.

Revenue and profitability of our healthcare facility operations, especially our community hospital operations, may be constrained by future cost containment initiatives undertaken by purchasers of healthcare services if SunLink is unable to contain costs.

Our community hospital operations derived approximately 43% of their net patient revenues for the fiscal year ended June 30, 2011 from private payors and other non-governmental sources who contributed approximately 18% of SunLink s patient days. Our hospitals have been affected by the increasing number of initiatives undertaken during the past several years by all major purchasers of healthcare, including (in addition to Federal and state governments) insurance companies and employers, to revise payment methodologies and monitor healthcare expenditures in order to contain healthcare costs. Initiatives such as managed care organizations offering prepaid and discounted medical services packages have adversely affected hospital revenue growth throughout the country and such packages represent an increasing portion of SunLink s admissions and outpatient revenues and have resulted in reduced revenue growth at our hospitals. In addition, private payers increasingly are attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations, referred to as PPOs. If we are unable to contain costs, especially in our hospital operations, through increased operational efficiencies and the trend toward declining reimbursements and payments continues, the results of healthcare facility segment operations and cash flow will be adversely affected and the results of our consolidated operations and our consolidated cash flow similarly likely would be adversely affected.

Our healthcare facilities, especially our community hospitals, face intense competition from other hospitals and healthcare providers which directly affect our segment and consolidated revenues and profitability.

Although each of our hospitals operates in communities where they are currently the only general, acute care hospital, they do face competition from other hospitals, including larger tertiary care centers. Although these competing hospitals may be as far as 30 to 50 miles away, patients in these markets may migrate to these competing facilities as a result of local physician referrals, managed care plan incentives or personal choice.

The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Each of our hospitals operates in geographic areas where they compete with at least one other hospital that provides services

comparable to those offered by our hospitals. Some of these competing facilities offer services, including extensive medical research and medical education

Index to Financial Statements

programs, which are not offered by SunLink s facilities. Some of the competing hospitals are owned or operated by tax-supported governmental bodies or by private not-for-profit entities supported by endowments and charitable contributions which can finance capital expenditures on a tax-exempt basis and are exempt from sales, property, and income taxes. In some of these markets, SunLink s hospitals also face competition from other for-profit hospital companies, some of which have substantially greater resources, as well as other providers such as outpatient surgery and diagnostic centers.

The intense competition from other hospitals and other healthcare providers directly affects the market share of our community hospitals, as well as their and our revenues and profitability.

Changes in market demographics may increase competition for certain of our community hospitals.

Some of our hospitals are located in exurban areas which are becoming more suburban or metropolitan. Such markets are likely to attract additional competitors, including satellite operations of tertiary hospitals. We cannot assure you that we will have the financial resources to fund capital improvements to our existing facilities, which may face additional competition or that even if financial resources are available to us, projected operating results will justify such expenditures. An inability to fund or the infeasibility of funding capital improvements could directly or indirectly have an adverse impact on hospital revenues through lower patient utilization, increased difficulty in physician recruitment and otherwise as a result of increased competition.

SunLink s hospitals are and our other healthcare facilities may be subject to, and depend on, certificate of need laws which could affect their ability to operate profitably.

All states in which SunLink currently operates hospitals and nursing homes have laws affecting acute care hospital facilities, nursing homes, ambulatory surgery centers and the provision of various services; such laws are known as certificate of need laws. Under such laws, prior state approval is required for the acquisition of major medical equipment or the purchase, lease, construction, expansion, sale or closure of covered healthcare facilities, based on a determination of need for additional or expanded facilities or services. The required approval is known generally as a certificate of need or CON. A CON may be required for capital expenditures exceeding a prescribed amount, changes in hospital and nursing home bed capacity or services, and certain other matters. The failure to obtain any required CON may impair SunLink s ability to operate profitably.

In addition, the elimination or modification of CON laws in states in which SunLink operates or in the future may own hospitals and other covered healthcare facilities could subject our hospitals to greater competition making it more difficult to operate profitably.

Risk Relating to our Specialty Pharmacy Business

The operations of our Specialty Pharmacy Segment may be adversely affected by changes in government reimbursement regulations and payment levels.

For the year ended June 30, 2011, the operations of our Specialty Pharmacy Segment derived approximately 64% of its net revenues from government payors, principally Medicare and Medicaid. The Deficit Reduction Act of 2005 exempted rural providers of home care related services from the competitive acquisition program to which urban providers are subject.

We cannot assure you that the ASP reimbursement methodology will not be extended to the provision of all specialty pharmaceuticals or to the specialty pharmaceuticals most often sold by the operations of our Specialty Pharmacy Segment or that we will continue to be able to operate our Specialty Pharmacy Segment profitably at either existing or at lower reimbursement rates. Likewise, we cannot assure you that the Part B CAP program will not be extended to rural or exurban areas in general or to the areas in which we operate, or may seek to operate, in particular or that we would be able to meet the qualifications to become a Part B CAP vendor either now or at any time in the future.

Index to Financial Statements

The operations of our Specialty Pharmacy Segment could be harmed by further changes in government purchasing methodologies and reimbursement rates for Medicare or Medicaid.

In addition to the impact of MMA implemented or inspired changes, in order to deal with budget shortfalls, some states are attempting to create state administered prescription drug discount plans, to limit the number of prescriptions per person that are covered, and to raise Medicaid co-pays and deductibles, and are proposing more restrictive formularies and reductions in pharmacy reimbursement rates. Any reductions in amounts reimbursable by other government programs for our services or changes in regulations governing such reimbursements could materially and adversely affect our business, financial condition and results of operations.

Our durable medical equipment service line may be adversely affected by changes in government reimbursement regulations and payment levels, especially if our durable medical equipment service line becomes subject to competitive bidding procedures.

Although we are currently exempted under the Deficit Reduction Act of 2005 from the competitive acquisition program for DMEPOS, we cannot be sure such exemption will continue to be available in the future. Loss of such exemption could have an adverse effect on our results of operation.

The operations of our Specialty Pharmacy Segment depend on a continuous supply of key products. Any shortages of key products could adversely affect our business.

Many of the biopharmaceutical products distributed by the operations of our Specialty Pharmacy Segment are manufactured with ingredients that are susceptible to supply shortages. In addition, the manufacturers of these products may not have adequate manufacturing capability to meet rising demand. If any products we distribute are in short supply for long periods of time, this could result in a material adverse effect on our business and results of operations.

The operations of our Specialty Pharmacy Segment are highly dependent on relationships with key suppliers and the loss of any of such key suppliers could adversely affect our business.

Any termination of, or adverse change in, our relationships with our key suppliers, or the loss of supply of one of our key products for any other reason, could have a material adverse effect on our business and results of operations. The largest supplier for our specialty pharmacy operations accounted for approximately 56% of Carmichael s total net sales in the fiscal year ended June 30, 2011. Our specialty pharmacy operations have a single source of supply for many of our key products, including one product which accounted for approximately 23% of Carmichael s total net sales in the fiscal year ended June 30, 2011. In addition, we have few long-term contracts with our suppliers. Our arrangements with most of our suppliers may be canceled by either party, without cause, on minimal notice. Many of these arrangements are not governed by written agreements.

The loss of one or more of our larger institutional pharmacy customers could hurt our business by reducing the revenues and profitability of the operations of our Specialty Pharmacy Segment.

As is customary in the institutional pharmacy industry, our Specialty Pharmacy Segment generally does not have long-term contracts with our institutional pharmacy customers. Significant declines in the level of purchases by one or more of our larger institutional pharmacy customers could have a material adverse effect on our business and results of operations.

Our failure to maintain eligibility as a Medicare and Medicaid supplier could materially adversely affect our competitive position. Likewise, our failure to maintain and expand relationships with private payors, who can effectively determine the pharmacy source for their members, could materially adversely affect our competitive position.

Index to Financial Statements

Changes in average wholesale prices could reduce our pricing and margins.

Many government payors, including Medicare and Medicaid, have paid, or continue to pay, the operations of our Specialty Pharmacy Segment directly or indirectly at a rate based upon a drug s AWP less a percentage factor. We also have contracted with some private payors to sell drugs at AWP or at AWP less a percentage factor. For most drugs, AWP is compiled and published by several private companies, including First DataBank, Inc. Several states have filed lawsuits against pharmaceutical manufacturers for allegedly inflating reported AWP for prescription drugs. In addition, class action lawsuits have been brought by consumers against pharmaceutical manufacturers alleging overstatement of AWP. We are not responsible for such calculations, reports or payments; however, there can be no assurance that the ability of our Specialty Pharmacy Segment to negotiate discounts from drug manufacturers will not be materially adversely affected by such investigations or lawsuits.

The Federal government also has entered into settlement agreements with several drug manufacturers relating to the calculation and reporting of AWP pursuant to which the drug manufacturers, among other things, have agreed to report new pricing information, the average sales price , to government healthcare programs. The average sales price is calculated differently than AWP.

We face numerous competitors and potential competitors in the market in which our Specialty Pharmacy Segment operates, many of whom are significantly larger and who have significantly greater financial resources.

Although we believe market penetration by large national companies into our existing market in which our Specialty Pharmacy Segment operates has not been substantial, we cannot assure you that one or more of such companies or other healthcare companies will not seek to compete or intensify their level of competition in the areas in which we conduct or may seek to conduct one or more of the components of the operations of our Specialty Pharmacy Segment.

The operations of our Specialty Pharmacy Segment may be adversely affected by industry trends in managed care contracting and consolidation.

A growing number of health plans are contracting with a single provider of specialty pharmacy services. Likewise, manufacturers may not be eager to contract with regional providers of specialty pharmacy services. If we are unable to obtain managed care contracts in the areas in which we provide specialty pharmacy services or are unable to obtain specialty pharmacy products at reasonable costs or at all, the business operations of our Specialty Pharmacy Segment could be adversely affected.

The specialty pharmacy market may grow slower than expected, which could adversely affect our revenues.

We cannot predict the rate of actual future growth in product availability and spending, the extent to which patient demand or spending for specialty drug services in rural or exurban areas will match national averages or whether government payors will provide reimbursement for new products under Medicare or Medicare on a timely basis, or at all, or at what rates. Adverse developments in any of these areas could have an adverse impact on the business operations of our Specialty Pharmacy Segment.

Other Risks

SunLink may issue additional equity in the future which could dilute the value of shares of existing shareholders.

SunLink s working capital is limited to cash generated from operations and borrowings available under the revolving loan facility in our current credit facility (a $9,000 revolving loan with $5,300 of the revolver outstanding and approximately $2,560 available to borrow at June 30, 2011) and our additional debt capacity is limited. On July 28, 2011, SunLink announced the private placement of approximately 1,338,000 common shares at $1.90 per share with certain of its officers and directors and/or their affiliates. The net proceeds of the private placement of approximately $2,500 were used, together with the Company s operating funds, to make an $8,000

Index to Financial Statements

pre-payment on the Credit Facility Term Loan. A special committee of the Company s Board of Directors comprised of disinterested directors evaluated the private placement transaction and obtained an opinion of an outside advisor selected by the special committee that the price and terms of the private placement were fair from a financial point of view to the Company. The Company s Board of Directors authorized the private placement before August 31, 2011 of a total of up to 3,800,000 of the Company s common shares at a price equal to the average closing price for the prior ten trading days (on which the Company s shares traded) with a minimum placement of $2,500. Although the Board of Directors has not decided to effect any additional equity transactions at this time, it may authorize the Company to do so in the future in connection with mergers and acquisitions, capital transactions or for other purposes. Any additional equity transactions could result in dilution in the value of existing shares.

Forward-looking statements in this annual report may prove inaccurate.

This document contains forward-looking statements about SunLink that are not historical facts but, rather, are statements about future expectations. Forward-looking statements in this document are based on management s current views and assumptions and may be influenced by factors that could cause actual results, performance or events to be materially different from those projected. These forward-looking statements are subject to numerous risks and uncertainties. Important factors, some of which are beyond the control of SunLink, could cause actual results, performance or events to differ materially from those in the forward-looking statements. These factors include those described above under *Risk Factors* and elsewhere in this report under *Forward-Looking Statements*.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

Our principal properties as of the date of filing of this report are listed below:

Name or Function	Location City and State	Licensed Beds	Date of Acquisition/Lease Inception	Ownership Type
Healthcare Facilities				
Chestatee Regional Hospital	Dahlonega, GA	49	February 1, 2001	Owned
North Georgia Medical Center & Gilmer Nursing Home	Ellijay, GA	50	February 1, 2001	Owned
Trace Regional Hospital & Floy Dyer Manor Nursing Home	Houston, MS	84	February 1, 2001	Owned
Callaway Community Hospital	Fulton, MO	49	October 3, 2003	Owned
Memorial Hospital of Adel & Memorial Convalescent Center	Adel, GA	60	October 3, 2003	Owned
Missouri Southern Healthcare(1)	Dexter, MO	50	February 1, 2001	Leased
Specialty Pharmacy Operations				
Carmichael Cashway Pharmacy(2)	Crowley, LA	N/A	April 22, 2008	Leased
Carmichael Cashway Pharmacy(3)	Lafayette, LA	N/A	April 22, 2008	Leased
Carmichael Cashway Pharmacy(4)	Lake Charles, LA	N/A	April 22, 2008	Leased
Other				
Chilton Medical Center(5)	Clanton, AL	N/A	February 1, 2001	Owned
Corporate Offices(6)	Atlanta, GA	N/A	June 1, 1998	Leased

(1) The lease expires in March, 2019.
(2) Lease of approximately 25,000 square feet of store location, warehouse and office space. The lease expires in April 2013 and provides for a renewal of the lease for two five year terms.

Index to Financial Statements

(3) Lease of approximately 5,900 square feet of store location and warehouse space. The lease expires in October 2011.
(4) Lease of approximately 4,000 square feet of store location and warehouse space. The lease expires in December 2011.
(5) Operations were sold February 28, 2011. The buyer owns the hospital license and leases the facility from SunLink with an option to purchase.
(6) Lease of approximately 4,800 square feet of office space for corporate staff. The lease was scheduled to expire in September 2009 but has been renewed through March 2015.

Item 3. ***Legal Proceedings***

On December 7, 2007, Southern Health Corporation of Ellijay, Inc. (SHC-Ellijay), a SunLink subsidiary, filed a Complaint against James P. Garrett and Roberta Mundy, both individually and as Fiduciary of the Estate of Randy Mundy (collectively, Defendants), seeking specific performance of an Option Agreement (the Option Agreement) dated April 17, 2007, between SHC-Ellijay, Mr. Garrett, and Ms. Mundy as Executrix of the Estate of Randy Mundy for the sale of approximately 24.74 acres of real property located in Gilmer County, Georgia, and recovery of SHC-Ellijay s damages suffered as a result of Defendants failure to close the transaction in accordance with the Option Agreement. SHC-Ellijay also stated alternative claims for breach of the Option Agreement and fraud, along with claims to recover attorney s fees and punitive damages.

In January 2008, Ms. Mundy and Mr. Garrett filed motions to strike, motions to dismiss, answers, affirmative defenses, and counterclaims against SHC-Ellijay. On March 3, 2009, SHC-Ellijay filed a First Amended and Restated Complaint for Damages, which effectively dropped the cause of action for specific performance of the Option Agreement. On May 7, 2009, Mr. Garrett and Ms. Mundy served a motion for summary judgment on all counts and causes of action stated in the First Amended Complaint, contending that Mr. Garrett and Ms. Mundy did not intentionally breach the Option Agreement. SHC-Ellijay filed opposition papers in June 2009 and requested a continuance. The court postponed consideration of the defendants motion for summary judgment and SHC-Ellijay s response thereto until after a discovery dispute between the parties was resolved and SHC-Ellijay had an opportunity to move for summary judgment. That discovery dispute was resolved and, after another discovery dispute was resolved, the parties completed discovery. In May 2011, SHC-Ellijay filed a motion for partial summary judgment on Count I of the Amended Complaint, seeking a judgment holding that Defendants willfully and intentionally breached the Option Agreement in eight ways, which would entitle SHC-Ellijay to recover damages from Defendants.

In July 2011, SHC-Ellijay filed a reply brief in further support of its motion for partial summary judgment on the complaint and full summary judgment on the Defendants counterclaims and brief in opposition to Defendants cross motion for summary judgment. The summary judgment motions remain pending.

SunLink denies that it has any liability to Mr. Garrett and Ms. Mundy and intends to vigorously defend the claims asserted against SunLink by Mr. Garrett s and Ms. Mundy s counterclaims and to vigorously pursue its claims against Mr. Garrett and Ms. Mundy. While the ultimate outcome and materiality of the litigation cannot be determined, in management s opinion the litigation will not have a material adverse effect on SunLink s financial condition or results of operations.

SunLink is a party to claims and litigation incidental to its business, for which it is not currently possible to determine the ultimate liability, if any. Based on an evaluation of information currently available and consultation with legal counsel, management believes that resolution of such claims and litigation is not likely to have a material effect on the financial position, cash flows, or results of operations of the Company. The Company expenses legal costs as they are incurred.

Item 4. ***Reserved***

41

Index to Financial Statements

PART II

Item 5. ***Market for Registrant s Common Equity and Related Stockholder Matters***

SunLink common shares are listed on the NYSE Amex Equities exchange. SunLink s ticker symbol is SSY . The following table shows, for the calendar quarters indicated, based on published financial sources, the high and low sale prices of SunLink common shares as reported on the NYSE Amex Equities exchange.

	Sales Price of SunLink Common Shares	
	High	Low
Fiscal 2011 (July 1, 2010 June 30, 2011)		
Fourth Quarter	$ 2.65	$ 1.50
Third Quarter	2.00	1.48
Second Quarter	2.40	1.40
First Quarter	2.40	1.75
Fiscal 2010 (July 1, 2009 June 30, 2010)		
Fourth Quarter	$ 3.63	$ 2.17
Third Quarter	4.19	1.44
Second Quarter	2.79	1.64
First Quarter	2.50	1.83

American Stock Transfer & Trust Company is the Transfer Agent and Registrar for our common shares. For all shareholder inquiries, call American Stock Transfer & Trust s Shareholder Services Department at 1-888-937-5449.

Dividends

SunLink does not currently pay cash dividends. SunLink intends to retain its earnings for use in the operation and expansion of its business and, therefore, does not anticipate declaring or paying regular cash dividends in the foreseeable future. Any future determination to declare or pay cash dividends will be determined by SunLink s board of directors and will depend on SunLink s financial condition, results of operations, business, prospects, capital requirements, credit agreements and such other matters as the board of directors may consider relevant. SunLink is currently precluded from paying any cash dividends under its current Credit Facility.

Holders

As of June 30, 2011 there were approximately 526 registered holders of SunLink common shares.

Index to Financial Statements

Securities Authorized for Issuance under Equity Compensation Plans

The following provides tabular disclosure of the number of securities at June 30, 2011 to be issued upon the exercise of outstanding options, the weighted average exercise price of outstanding options and the number of securities remaining available for future issuance under equity compensation plans, reported by two categories- plans that have been approved by shareholders and plans that have not been so approved:

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options	(b) Weighted average exercise price of outstanding options	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by security holders:			
2001 Outside Directors Stock Ownership and Stock Option Plan	45,000	$ 4.37	0
2001 Long-Term Stock Option Plan	13,250	$ 3.96	0
2005 Equity Incentive Plan	115,999	$ 9.88	614,676
	174,249	$ 5.91	614,676
Equity compensation plans not approved by security holders:			
None	0	0	0
Total	174,249	$ 5.91	614,676

Index to Financial Statements

Performance Graph

The following graph presents a comparison of five years cumulative total return for SunLink, the NYSE Amex Equities exchange Composite Index and a self constructed peer group. The peer group consists of Amsurg Corp., Community Health Systems Inc., Dynacq Healthcare Inc., Health Management Association Inc., Lifepoint Hospitals Inc., Magellan Health Services Inc., Medcath Corp., Paincare Holdings Inc., Tenet Healthcare Corp., and Universal Health Services Inc. There is no assurance the Hospital Index peer group or NYSE Amex Equities Composite is comparable to SunLink, because, among other reasons, both consist of larger companies than SunLink.

	6/06	6/07	6/08	6/09	6/10	6/11
SunLink Health Systems, Inc.	**100.00**	**63.84**	**48.59**	**21.92**	**22.78**	**19.19**
NYSE Amex Equities Composite	**100.00**	**125.36**	**124.63**	**92.01**	**108.97**	**146.13**
Hospitals Index	**100.00**	**110.71**	**89.82**	**67.47**	**90.83**	**113.16**

Index to Financial Statements

Item 6. ***Selected Financial Data***

Selected historical financial data presented below as of and for the fiscal years ended June 30, 2011, 2010, 2009, 2008 and 2007 have been derived from the audited consolidated financial statements of SunLink. The following financial information reflects the acquisition of our two HealthMont hospitals and Carmichael and the disposition of Mountainside Medical Center, Chilton Medical Center and three home health agencies. This data should be read in conjunction with Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations, and the Consolidated Financial Statements of SunLink and the notes thereto included in Item 8 of this Annual Report.

SunLink Selected Historical Financial Data

(All amounts in thousands, except per share amounts)

	2011	2010	2009	2008	2007
Net Revenues	$ 181,161	$ 183,166	$ 181,561	$ 142,885	$ 130,495
Earnings (loss) from continuing operations	(10,552)	(858)	805	2,113	2,586
Net earnings (loss)	(10,715)	102	912	1,720	2,405
Earnings (loss) per share from continuing operations					
Basic	(1.30)	(0.11)	0.10	0.28	0.35
Diluted	(1.30)	(0.11)	0.10	0.27	0.33
Net earnings per share:					
Basic	(1.32)	0.01	0.11	0.23	0.33
Diluted	(1.32)	0.01	0.11	0.22	0.31
Total Assets	89,536	98,490	107,383	111,624	77,843
Long-term debt, including current maturities	31,752	33,437	35,545	37,963	8,563
Shareholders equity	$ 31,456	$ 42,692	$ 42,392	$ 40,244	$ 36,024

Item 7. ***Management s Discussion and Analysis of Financial Condition and Results of Operations (all dollar amounts in thousands, except per share and revenue per equivalent admissions amounts)***

This Annual Report and the documents that are incorporated by reference in this Annual Report contain certain forward-looking statements within the meaning of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that do not relate solely to historical or current facts and may be identified by the use of words such as may, believe, will, seeks to , expect, project, estimate, anticipate, plan or continue. These forward-looking stat the current plans and expectations and are subject to a number of risks, uncertainties and other factors which could significantly affect current plans and expectations and our future financial condition and results. For a listing and a discussion of such factors, which could cause actual results, performance and achievements to differ materially from those anticipated, see Certain Cautionary Statements Forward Looking Information and Item 1A included elsewhere in this Annual Report on Form 10-K.

Critical Accounting Estimates

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

it requires assumptions to be made that were uncertain at the time the estimate was made; and

changes in the estimate or different estimates that could have been made could have a material impact on our consolidated statement of earnings or financial condition.

The table of critical accounting estimates that follows is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 2 of our Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K for the

Index to Financial Statements

fiscal year ended June 30, 2011, the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and financial condition.

The table that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate:

Balance Sheet or Income Statement

Caption/Nature of Critical Estimate Item	Assumption / Approach Used	Sensitivity Analysis
(dollar amounts in thousands, except per share)	**(dollar amounts in thousands, except per share)**	**(dollar amounts in thousands, except per share)**
Receivables-net and Provision for Bad Debts		
Receivables-net for our Healthcare Facilities Segment primarily consists of amounts due from third-party payors and patients from providing healthcare services to hospital facility patients. Receivables-net for our Specialty Pharmacy Segment primarily consists of amounts due from third-party payors; institutions such as nursing homes, home health, hospice, hospitals; pharmacy stores; Medicaid Part D program; and customers from the sale of pharmacy services and merchandise. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. Our allowance for doubtful accounts, included in our balance sheets as of June 30 was as follows: 2011 $12,317; and 2010 $14,725.	The largest component of bad debts in our patient accounts receivable for our healthcare facilities and Specialty Pharmacy Segments relates to accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. In general, we attempt to collect deductibles, co-payments and self-pay accounts prior to the time of service for non-emergency care. If we do not collect these patient responsibility accounts prior to the delivery of care, the accounts are handled through our billing and collections processes. We attempt to verify each patient s insurance coverage as early as possible before a scheduled non-emergency admission or procedure, including with respect to eligibility, benefits and authorization/pre-certification requirements, in order to notify patients of the estimated amounts for which they will be responsible. We attempt to verify insurance coverage within a reasonable amount of time for all emergency room visits and non-emergency urgent admissions in compliance with the Emergency Medical Treatment and Active Labor Act.	A significant increase in our provision for doubtful accounts (as a percentage of revenues) would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and potentially our future access to capital. If net revenues during fiscal year 2011 were changed by 1%, our 2011 after-tax income from continuing operations would change by approximately $1,196 or diluted earnings per share of $0.15. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate uncollectible patient accounts that are highly uncertain and requires a high degree of judgment. It is impacted by, among other things, changes in regional economic conditions, business office operations, payor mix and trends in private and federal or state governmental healthcare coverage.

Index to Financial Statements

Balance Sheet or Income Statement

Caption/Nature of Critical Estimate Item	Assumption / Approach Used	Sensitivity Analysis
(dollar amounts in thousands, except per share)	**(dollar amounts in thousands, except per share)**	**(dollar amounts in thousands, except per share)**
Receivables-net and Provision for Bad Debts (continued)		
Our provision for bad debts, included in our results of operations, was as follows: 2011 $19,690; 2010 $22,592; and 2009 $19,735.	In general, we utilize the following steps in collecting accounts receivable: if possible, cash collection of all or a portion of deductibles, co-payments and self-pay accounts prior to or at the time service is provided; billing and follow-up with third party payors; collection calls; utilization of collection agencies; sue to collect if the patient has the means to pay and chooses not to pay; and if collection efforts are unsuccessful, write off the accounts. Our policy is to write off accounts after all collection efforts have failed, which is typically no longer than 120 days after the date of discharge of the patient or service to the patient or customer. Patient responsibility accounts represent the majority of our write-offs. All of our hospitals retain third-party collection agencies for billing and collection of delinquent accounts. At most of our hospitals, more than one collection agency is used to promote competition and improved performance. The selection of collection agencies and the timing of the referral of an account to a collection agency vary among hospitals. Generally, we do not write off accounts prior to utilizing the services of a collection agency. Once collection efforts have proven unsuccessful, an account is written off from our patient accounting system against the allowance for doubtful accounts.	

Index to Financial Statements

Balance Sheet or Income Statement		
Caption/Nature of Critical Estimate Item	**Assumption / Approach Used**	**Sensitivity Analysis**
(dollar amounts in thousands, except per share)	**(dollar amounts in thousands, except per share)**	**(dollar amounts in thousands, except per share)**
Receivables-net and Provision for Bad Debts (continued)	We determine the adequacy of the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the adequacy of the allowance. We monitor our revenue trends by payor classification on a quarter-by-quarter basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, accounts receivable, co-payment receivables and historic payment patterns. In addition, we analyze other factors such as day s revenue in accounts receivable and we review admissions and charges by physicians, primarily focusing on recently recruited physicians.	

	Days Outstanding[1]							
Payor Class	**0-30**	**31-60**	**61-90**	**91-120**	**121-150**	**151-180**	**>180**	**Total**
Medicare	$ 3,315	$ 343	$ 241	$ 172	$ 68	$ 49	$ 257	$ 4,445
Commercial	2,361	592	315	178	118	76	383	4,023
Medicaid	1,777	375	281	182	112	107	460	3,294
Self Pay	187	168	145	94	62	40	213	909
	$ 7,640	$ 1,478	$ 982	$ 626	$ 360	$ 272	$ 1,313	$ 12,671

[1] The above table shows, as of June 30, 2011, net hospital patient accounts receivable aged from patient date of service and are grouped by classification of verified insurance coverage. The receivables are net of contractual allowances and allowance for doubtful accounts. Contractual allowances and the allowance for doubtful accounts are calculated by payor class and are not calculated by the aging of the patient billing date; therefore, these allowances have been allocated within the aging of the various payor classes based upon gross patient receivable amounts.

Index to Financial Statements

Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Revenue recognition / Net Patient		
Service Revenues		
For our Healthcare Facilities Segment, we recognize revenues in the period in which services are provided. For our Specialty Pharmacy Segment, we recognize revenues in the period in which services are provided and at the time the customer takes possession of merchandise. Patient receivables primarily consist of amounts due from third-party payors and patients. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors, such as HMOs, PPOs and other private insurers, are determined pursuant to contracts or established government rates and are generally less than our established billing rates. Accordingly, our gross revenues and patient receivables are reduced to net amounts receivable pursuant to such contracts or government payment rates through an allowance for contractual discounts. Approximately 85.0%, 82.8% and 86.4% of our revenues during the years ended June 30, 2011, 2010 and 2009, respectively, relate to discounted charges. The sources of these revenues were as follows (as a percentage of total revenues): Medicare 43.2%; Medicaid 14.3%; and Commercial insurance 27.5%.	Revenues are recorded at estimated amounts due from patients, third-party payors, institutions, pharmacies, and others for healthcare and pharmacy services and goods provided net of contractual discounts pursuant to contract or government payment rates. Estimates for contractual allowances are calculated using computerized and manual processes depending on the type of payor involved. In certain hospitals, the contractual allowances are calculated by a computerized system based on payment terms for each payor. In other hospitals, the contractual allowances are estimated manually using historical collections for each type of payor. For all hospitals, certain manual estimates are used in calculating contractual allowances based on historical collections from payors that are not significant or have not entered into a contract with us. All contractual adjustments regardless of type of payor or method of calculation are reviewed and compared to actual experience on a periodic basis. Accounts receivable primarily consist of amounts due from third party payors, institutions, pharmacies, and patients. Amounts we receive for the treatment of patients covered by HMOs, PPOs and other private insurers are generally less than our established billing rates. We include contractual allowances as a reduction to revenues in our financial statements based on payor specific identification and payor specific factors for rate increases and denials.	

Index to Financial Statements

Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Revenue recognition / Net Patient Service Revenues (continued)		
Included in the Healthcare Facilities Segment s Medicare and Medicaid net revenues for fiscal 2011 are reimbursements under the Electronic Health Records (EHR) provisions of the Health Information Technology for Economic and Clinical Health Act (the HITECH Act). The HITECH Act was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA). EHR reimbursements included in Healthcare Facilities Segment net revenues for fiscal 2011 are as follows: **2011** Medicare $ 7,683 Medicaid 1,243 Total $ 8,926	**Governmental payors** The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under this prospective reimbursement system, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates. Discounts for retrospectively cost-based revenues, which were more prevalent in periods before 2000, are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under all programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. **Commercial Insurance** For most managed care plans, contractual allowances estimated at the time of service are adjusted to actual contractual allowances as cash is received and claims are reconciled. We evaluate the following criteria in developing	**Governmental payors** Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates of contractual discounts we record could change by material amounts. Adjustments related to final settlements for revenues retrospectively increased our revenues by the following amounts: 2011 $766; 2010 $1,194; and 2009 $233. **Commercial Insurance** If our overall estimated contractual discount percentage on all of our commercial revenues during 2011 were changed by 1%, our 2011 after-tax income from continuing operations would change by approximately $256.

Index to Financial Statements

Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Revenue recognition / Net Patient Service Revenues (continued)	the estimated contractual allowance percentages: historical contractual allowance trends based on actual claims paid by managed care payors; review of contractual allowance information reflecting current contract terms; consideration and analysis of changes in payor mix reimbursement levels; and other issues that may impact contractual allowances.	This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.
Goodwill, other intangible assets and accounting for business combinations Goodwill represents the excess of the purchase price over the fair value of the net assets (including separately identified intangible assets) of acquired companies. The Company has two reportable business segments that with goodwill. Our goodwill by business segment included in our consolidated balance sheets as of June 30 for the following years was as follows: **2011** **2010** Healthcare Facilities $2,515 $2,515 Pharmacy 461 6,509 Total Goodwill $2,976 $9,024 The goodwill resulted from the 2004 acquisition of HealthMont, Inc. and the 2008 acquisition of Carmichael. The Company s intangible assets relate to Certificates of Need (CON), non-competition agreements, trade name, customer relationships and Medicare licenses.	In accordance with FASB Accounting Standards Codification (ASC) 350-10, Intangibles Goodwill and Other, (ASC 350-10) goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. For purposes of these analyses, our estimate of fair value is based on the income approach, which estimates the fair value based on our future discounted cash flows. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. If we determine the carrying value of goodwill or other intangible assets to be impaired, then we reduce the carrying value. The purchase price of acquisitions is allocated to the assets acquired and liabilities assumed based upon their respective fair values and are subject to change during the	As part of the fiscal 2011 goodwill and intangibles impairment analysis, the Company recognized that there has been significant declines in net revenue during FY 2011 for the Specialty Pharmacy Segment. The analysis resulted in a $6,048 goodwill impairment charge for fiscal 2011. Additionally, the Company recognized a $3,400 impairment charge to trade name and a $3,899 impairment charge to customer relationships for the fiscal year ended June 30, 2011.

Index to Financial Statements

Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Goodwill, other intangible assets and accounting for business combinations (continued)		
CON, Non-competition agreements, customer relationships, and Medicare licenses are amortized over the terms of the agreements. The trade name has been determined to have an indefinite life and, accordingly, is not amortized. Our other intangible assets by business segment included in our consolidated balance sheets as of June 30 for the following years was as follows:	twelve month period subsequent to the acquisition date. We engage independent third-party valuation firms to assist us in determining the fair values of assets acquired and liabilities assumed at the time of acquisition. Such valuations require us to make significant estimates and assumptions, including projections of future events and operating performance.	

	2011	2010
Healthcare Facilities		
Certificates of Need	$ 630	$ 630
Noncompetition agreements	83	83
	713	713
Accumulated amortization	(280)	(226)
	$ 433	$ 487
Pharmacy		
Trade name	$ 2,000	$ 5,400
Customer relationships	1,089	6,400
Medicare License	769	769
	3,858	12,569
Accumulated amortization	(453)	(1,280)
	$ 3,405	$ 11,289
Total	$ 3,838	$ 11,776

	Fair value estimates are derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows. Our estimate of future cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.	
Professional and general liability claims		
We are subject to potential medical malpractice lawsuits and other claims as part of providing healthcare services. To mitigate a portion of this risk, we have maintained insurance for individual malpractice claims exceeding a self-insured retention amount. For the periods March 1, 2008 to February 28, 2009, March 1, 2009 to February 2010, March 1, 2010 to	The reserve for professional and general liability claims is based upon independent actuarial calculations, wh	