SUNLINK HEALTH SYSTEMS INC
Form 10-K
September 27, 2013
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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, 2013

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 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 x 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	¨ (Do not check if a smaller reporting company)	Smaller reporting company	x

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 27, 2013, there were 9,443,408 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, 2012 of the registrant s common shares as reported by NYSE Amex Equities stock exchange amounted to $3,549,704.

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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 11, 2013, 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, 2013.

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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;

increases in uninsured and/or underinsured patients due to unemployment, higher deductibles and co-insurance, terms of health insurance coverage or other conditions resulting in higher bad debt amounts;

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

demographic changes in areas where we operate;

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;

changes in interest rates under debt agreements;

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

restrictions imposed by existing debt agreements;

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

the efforts of government payors, 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 in 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;

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

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

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

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

the availability of 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;

Federal and state insurance exchanges and their rules on reimbursement terms;

the regulatory environment for our businesses, including state certificate of need laws, 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 additional federal healthcare reform laws or reform laws in states where we operate hospital and pharmacy facilities (including Medicare and Medicaid waivers, bundled payments, accountable care and similar organizations, competitive bidding and other reforms).

Dispositions, Acquisitions, and Renovation Related Matters

the ability to dispose of underperforming facilities;

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

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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.

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PART I

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

Overview

SunLink Health Systems, Inc., through subsidiaries, owns businesses which are a provider of healthcare services in certain markets in the United States. Unless the context indicates otherwise, all references to SunLink, we, our, ours, us and the Company refer to SunLink Health S Inc. and our consolidated subsidiaries. References to our specific operations refer to operations conducted through our subsidiaries and references to we, our, ours, and us in such context refer to the operations of our subsidiaries. Our business is composed of the ownership of tw business segments, the Healthcare Facilities Segment and the Specialty Pharmacy Segment. Our Healthcare Facilities Segment subsidiaries own and operate a total of four community hospitals in three states. Our community hospitals are acute care hospitals and have a total of 232 licensed beds. As part of the community hospital operations, our subsidiaries currently also operate two nursing homes in two states, each of which is located adjacent to, or in close proximity with, one of the community hospitals. The nursing homes have a total of 166 licensed beds. A subsidiary also owns a hospital building that is currently being re-purposed as a multi-tenant medical park. Our Specialty Pharmacy Segment subsidiary operates a specialty pharmacy business in Louisiana with four service lines.

SunLink s 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 incorporated in June 1959. In 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. We subsequently have acquired two hospitals and sold three hospitals and three home health businesses. We also sold the operations of one hospital to a buyer who leased the hospital building from us but which subsequently ceased its hospital operations. In 2008 a wholly-owned subsidiary acquired Carmichael s Cashway Pharmacy, Inc. (Carmichael) which provides services to patients in rural communities in southwest Louisiana and eastern Texas.

Business Strategy: Operations, Dispositions and Acquisitions, and Going Private

SunLink s business strategy is to focus its efforts on improving internal operations of its existing healthcare facilities and its pharmacy business. We also consider from time to time potential healthcare acquisitions and dispositions, including but not limited to hospitals, physician clinics, ambulatory surgery centers, nursing and long-term care homes, medical office buildings and pharmacy businesses. We consider dispositions of facilities or operations based on a variety of factors including asset values, return on investments, competition from existing and potential competitors, capital improvement needs, corporate strategy and other corporate objectives.

Operations Strategy

Our operational strategy seeks to improve the operations and profitability of our community hospitals by reducing out-migration of patients, recruiting physicians, expanding services and implementing and maintaining effective cost controls (including terminating and/or replacing unprofitable services). Our operational strategy for

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the nursing homes is similar to that for the 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.

Disposition and Acquisition Strategy

Our efforts over the last two years have been more focused on the disposition of hospital facilities than on acquisitions due to our financial position and need to reduce our leverage and interest expense, the changing nature of certain of our subsidiary hospital markets resulting in, among other things, substantial additional competition, and pressure from Federal and state programs (e.g., Medicare and Medicaid) and private payors to reduce reimbursement for medical services. In July 2012, we sold our Adel, Georgia hospital and its related nursing home, and in December 2012, we sold our Dexter, Missouri hospital and its related home health agency. We currently have engaged advisors to advise us on and to assist us with the possible sale of three other hospital facilities.

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

Historically, we have 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 although competition has increased substantially in recent years in each market, (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, opportunities 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, our financial position, 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.

Extensive competition exists 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, related services (such as physician clinics and practices), and other healthcare facilities could have an adverse effect on our ability to acquire such healthcare businesses 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 not-for profit and for-profit hospital operators seek to re-align the focus of their portfolios. Certain of these hospitals may be closed (such as our Clanton, Alabama hospital) and our evaluation could focus on re-opening them with different or additional services which are needed in the community and which may or may not include acute-care services and may not require a hospital Certificate of Need (CON) or license.

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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.

Going Private Strategy

On February 5, 2013, the Company announced the commencement of a tender offer to purchase at the price of $1.50 per share in cash all of its common shares held by holders of 99 or fewer shares (odd lots) who owned such shares as of the close of business on February 1, 2013 (Odd Lot Tender Offer). In addition to the $1.50 per share price, the Company offered each eligible tendering holder a bonus of one hundred dollars ($100) upon completion of the Odd Lot Tender Offer for the tender of all shares beneficially owned by such holder which were received and not withdrawn prior to the date of expiration of the Odd Lot Tender offer, which was March 26, 2013. In accordance with the terms and conditions of the Offer, SunLink accepted for purchase a total of 2,631 common shares of SunLink tendered by 68 holders pursuant to the Offer. As a result of the completion of the Offer, immediately following payment for the tendered shares, the Company had approximately 9,443,000 common shares issued and outstanding and held by approximately 480 stockholders of record.

The primary purpose of the Odd Lot Tender Offer was to reduce the number of holders of record of the Company s common shares in order to permit the Company to deregister the common shares with the SEC. The Board and management each continues to believe that deregistering the Company s common shares would result in significant cost savings. Since the Odd Lot Tender Offer did not result in the Company s qualifying to deregister with the SEC, the Board will likely consider other alternatives to achieve that result, including a further tender offer, a reverse stock split or cash out merger (in which a new corporation is formed to merge with the Company and holders of Company shares are cashed out), so long as the Board continues to believe that deregistration remains in the Company s best interests. For an extended discussion of the purposes and reasons for going private, see Section 2 of the Company s Offer to Purchase filed as Exhibit 99.A.1.A to the Company s Schedule 13E-3 filed with the SEC on February 5, 2013.

Healthcare Facilities Operations

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

- Four community hospital in three states, having an aggregate of 232 beds, each of which is owned by a SunLink subsidiary;
- Two nursing homes with an aggregate of 166 beds, each of which nursing home is owned by a hospital subsidiary and located adjacent to, or in close proximity with its corresponding community hospital; and
- Our Clanton, Alabama facility which is currently being re-purposed as a multi-tenant medical park.

Owned Hospitals

All of the hospitals which our subsidiaries operate are owned. The following sets forth certain information with respect to each of the four community hospitals:

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 Organizations (JCAHO). It includes a 12-bed obstetric department, a four-bed intensive care unit

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(ICU) a 33-bed medical/surgical/pediatrics unit, and 10-bed geriatric psychiatric unit (GPU). 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 CON to add a 10-bed inpatient geriatric psychiatric program. North Georgia also leases a 41,985 square foot multi-purpose medical building from another SunLink subsidiary.

Trace Regional Hospital (Trace), located in Houston, Chickasaw County, Mississippi, consists of a JCAHO accredited 84-licensed-bed, acute care hospital, which includes a 15-bed GPU, and Floy Dyer Manor Nursing Home, a 66-bed nursing home. Trace is the only hospital in Chickasaw County.

Callaway Community Hospital (Callaway), located in Fulton, Callaway County, Missouri, consists of a 49-licensed-bed, JCAHO accredited, acute care hospital which includes a 19-bed GPU. Callaway is the only hospital in Callaway County.

A subsidiary also owns the Careside Medical Park (Careside) hospital building located in Clanton, Chilton County, Alabama which is being repurposed as a multi-tenant medical park.

Hospital Operations

Utilization of Local Hospital Management Teams

We believe that the long-term potential of our subsidiary hospitals is dependent on their ability to offer appropriate healthcare services and effectively recruit and retain physicians. Each subsidiary 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 subsidiary 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 the board of directors for the applicable subsidiary. Each subsidiary 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 subsidiary hospital management team is responsible for the day-to-day operations of its hospital. Each subsidiary has access to support services, assistance, and advice 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 some of which may be provided by SunLink or other SunLink subsidiaries. Financial controls are maintained through the utilization of policies and procedures and monitoring by the subsidiary board of directors. Each subsidiary hospital has contracted with the HealthTrust Group Purchasing Organization, a purchasing group used by a large number of community hospitals, for certain supplies and equipment.

Expansion of Services and Facilities

Each subsidiary hospital seeks to add services at on an as-needed basis in order to improve access to quality healthcare services in the communities it serves, 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 subsidiary hospital s quality of care and

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reputation in the community, reducing out-migration and increasing patient referrals and revenue. Each hospital endeavors to provide a quality, patient-friendly emergency room as a critical component of its local service offering and which is intended to function as each facility s window to the community .

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. Each subsidiary hospital seeks to retain primary care physicians of varied physician specialties on its medical staff to attract other qualified physicians. Physicians generally refer patients to a hospital primarily on the basis of the perceived 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, each subsidiary hospital strives to provide quality facilities, equipment, employees and services for physicians and their patients.

Physician Recruiting

Each subsidiary 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 team, with the assistance of outside recruiting firms, identifies and seeks to attract specific physicians to its hospital s medical staff. Increasingly, each of our subsidiary hospitals has employed physicians to better align physician performance with hospital goals through employment relationships. Many hospitals and hospital systems are attempting to improve clinical and financial results by employing physicians. For newly recruited non-employed physicians, the hospital generally guarantees such physicians a minimum level of gross receipts during an initial period, generally of 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, 20 physicians are employed by our subsidiary hospitals and three are under physician guarantee contracts. Each hospital periodically evaluates each doctor and may terminate employment based on doctor performance and the needs of each facility. Physician recruiting has become more challenging and such recruiting will continue to remain challenging due to various factors including healthcare reform and market forces. The costs of recruiting and retaining physicians are also expected increase as more physicians are employed and salaries and support costs increase.

Quality Assurance

Each 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 subsidiary 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 hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations, also known as JCAHO.

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Operating Statistics

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

	Fiscal Years Ended June 30,		
	2013	2012	2011
Hospitals owned or leased at end of period	4	4	4
Licensed hospital bed (at end of period)	232	232	232
Hospital beds in service (at end of period)	173	173	173
Nursing home beds in service (at end of period)	166	166	166
Admissions	3,448	3,525	4,148
Equivalent Admissions (1)	11,542	12,522	12,642
Average Length of Stay (2)	4.8	3.7	3.7
Patient days	16,627	12,880	15,312
Adjusted patient days (3)	57,112	44,333	45,944
Occupancy rate (% of licensed beds)(4)	19.64%	15.21%	18.08%
Occupancy rate (% of beds in service)(5)	26.33%	20.40%	24.25%
Net patient service revenues (in thousands)	$ 74,911	$ 75,090	$ 80,428
Net outpatient service revenues (in thousands)	$ 27,584	$ 39,258	$ 43,275
Net revenue per equivalent admissions	$ 6,459	$ 5,966	$ 6,350
Net outpatient service revenues (as a % of net patient service revenues)	36.82%	52.28%	53.81%

(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 subsidiary 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 hospital beds.

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

Sources of Revenue

Each subsidiary 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 subsidiary 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 .

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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,		
	2013	2012	2011
Source			
Medicare	80.8%	68.3%	71.8%
Medicaid	6.2%	10.0%	10.1%
Private and Other Sources	13.0%	21.7%	18.1%
	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,		
	2013	2012	2011
Source			
Medicare	41.1%	41.1%	42.0%
Medicaid	15.5%	16.7%	15.9%
Private and Other Sources	43.4%	42.2%	42.1%
	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 Medicare patient days increased significantly in fiscal year 2013 due to the opening of the geriatric psychiatric units (GPU) at two hospital facilities. Total patient days for the two new GPUs were 28% of total patient days, or 4,671. 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 subsidiary hospital markets are:

The appearance and functionality of the healthcare facilities;

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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.

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 subsidiary hospitals face competition from larger tertiary care centers and, in most 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 subsidiary hospitals, likely have greater access to financial resources than do our subsidiary hospitals.

Managed Care

Each subsidiary 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. Nevertheless, a significant portion of hospital patients in our communities in which our subsidiary hospitals operate 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 the hospitals owned and operated by SunLink s subsidiaries, 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 hospitals owned and operated by SunLink s subsidiaries have responded to such trends by adding and expanding outpatient services, upgrading facilities and equipment, offering new programs (such as geriatric psychiatric units) and adding or expanding certain inpatient and ancillary services. Currently we expect our subsidiaries hospitals will 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.

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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 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 or pay a tax penalty, 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 are taking effect in 2013, 2014 or 2015 and many of the rules and regulations that implement the provisions of the ACA have not been finalized, it is difficult to predict the impact the ACA will have on the hospital facilities. However, we believe it is likely that the implementation or interpretation of such rules and regulations or the provisions of the ACA may be having an adverse effect on our financial condition and results of our operations.

Government Reimbursement Programs

A significant portion of SunLink s healthcare facilities net revenues are dependent upon reimbursement to our subsidiaries hospitals 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 currently pays hospitals under the provisions of a prospective payment system for most 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 (FFY). 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 and other factors imposed by CMS.

DRG rate increases were 1.1% and 2.8% for FFY 2012 and 2013, respectively, and currently is 0.7% for FFY 2014. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future FFYs 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. Beginning in FFY 2012 the market basket rate began to be reduced by two such reduction factors. First as required by the ACA, the market basket rate is reduced by 0.25%. Second, CMS is applying a documentation

and coding adjustment to recoup a portion of perceived excess aggregate payments

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in FFY 2008 and FY 2009 that did not reflect actual increases in patients severity of illness. Under legislation passed in 2007, CMS was required to recoup the entire amount of FFY 2008 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 the cost of providing inpatient services by our subsidiaries hospitals, our financial condition or results of operations could be negatively affected.

The ACA combined with the America Taxpayer Relief Act of 2012 (ATRA) 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, including to incorporate an adjustment for expected productivity gains. The market basket was reduced by 0.25% for both FFY 2010 and 2011, 0.10% for FFY 2012 and 0.10% in FFY 2013; and will be reduced 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, 2013.

- 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 were effective for FFYs 2011 through 2013. Effective FFY 2014, the low-volume hospital definition and payment adjustment methodology returned to the pre-FFY 2011 definition and methodology.

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

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 2012 and 2013 the update factors were 3.0% and 2.6%, respectively and for calendar year 2014 is expected to be 1.8%. If the update factor for current and future periods does not adequately reflect increases in SunLink s subsidiaries hospitals 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 partially added to, and reimbursed as portion of, 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 the respective Medicare Auditor Contractor (MAC) from the prior cost report filing, and which are finally adjusted when cost reports are filed and audited.

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 provider must be able to show the debt was actually uncollectible when claimed as worthless; and

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the provider must be able to show 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 was reduced by 30% prior to October 1, 2013 and will be reduced by 35% beginning FFY 2014. Under the Medicare bad debt reimbursement provisions, our subsidiaries hospitals received an aggregate of approximately $1,442, $1,261 and $1,018 for 2010, 2011 and 2012, respectively. Our hospitals reported an aggregate amount of Medicare bad debt reimbursements of approximately $1,164 for 2013. The 2013 reported amounts are subject to final settlement of the fiscal year 2013 cost reports.

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 subsidiaries hospitals were classified as disproportionate share hospitals at June 30, 2013. The Affordable Care Act provides for material reductions in Medicare DSH funding. We estimate that Medicare disproportionate share payments represented approximately 1% of our net patient service revenues for the years ended June 30, 2013, 2012 and 2011.

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 states in which our subsidiaries operate 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 or 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 provided a temporary increase in the state FMAPs during a 9-calendar quarter recession adjustment period retroactively, which began October 1, 2008 and which ended 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 states where SunLink operates were postponed until January 1, 2011.

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The states in which SunLink subsidiaries operate hospitals have implemented initiatives to decrease the Medicaid funds paid to providers. 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 subsidiaries hospitals 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 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 Georgia 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, two hospitals operated by a SunLink subsidiary in Georgia 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.

If SunLink or our subsidiaries or any of their facilities were found to be in violation of federal or state laws relating to Medicare, Medicaid or similar programs, SunLink or the applicable subsidiary or facility 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.

Adoption of Electronic Health Records

Electronic Health Records (EHR) incentive reimbursements are payments received under the Health Information Technology for Economic and Clinical Health Act (the HITECH Act) which was enacted into law on February 17, 2009 as part of ARRA. The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. Beginning with federal fiscal year 2011 (federal fiscal year is October 1 through September 30) and extending through federal fiscal year 2016, eligible hospitals participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of their certified EHR technology. Conversely, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

The Company accounts for EHR incentive payments in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 450-30, Gain Contingencies (ASC 450-30). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when the applicable eligible subsidiary hospital has demonstrated meaningful use of certified EHR technology for the applicable period and when the cost report information needed for the full cost report year used for the final calculation of the EHR incentive reimbursement payment is available. The demonstration of meaningful use is based on meeting a series of objectives and varies among hospitals, between the Medicare and Medicaid programs, and within the Medicaid program from state to state. Additionally, meeting the series of objectives in order to demonstrate meaningful use becomes progressively more stringent as its implementation is phased in through stages as outlined by the CMS.

Attestation of Medicare meaningful use requirements was successful for each of SunLink s hospital subsidiaries continuing and certain discontinued operations for fiscal year ended June 30, 2013 and for the

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continuing and certain discontinued operations for the fiscal year ended June 30, 2012. SunLink s hospital subsidiaries have also successfully attested to the meaningful use requirements for the Medicaid program for continuing and certain discontinued operations for the fiscal year ended June 30, 2013 and for fiscal year ended June 30, 2012. EHR incentive payments received were as follows:

	2013			2012		
	Medicare	Medicaid	Total	Medicare	Medicaid	Total
Continuing Operations	$ 4,121	$ 1,220	$ 5,341	$ 5,836	$ 1,549	$ 7,385
Discontinued Operations	1,136	248	1,384	2,685	808	3,493
	$ 5,257	$ 1,468	$ 6,725	$ 8,521	$ 2,357	$ 10,878

The amounts in the table above represent actual funds received from meeting the meaningful use requirements for Medicare and Medicaid programs. Amounts recognized may differ due to year-end adjustments and final settlement of cost reports.

SunLink s subsidiaries hospitals seek to continue to comply with the EHR meaningful use requirements of the HITECH Act in time to qualify for available incentive payments. We believe their compliance will result in significant costs including professional services focused on successfully designing and implementing EHR solutions along with costs associated with the hardware and software components of the project. As a result of prior expenditures on information technology systems, the previously existing information technology systems at our subsidiaries hospitals already possessed certain components required for meaningful use of EHR technology. We continue to refine our budgeted costs and the expected reimbursement associated with subsidiaries hospitals 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.

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 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 subsidiary 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

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examine Medicare claims filed by healthcare providers. The RAC program was made permanent by the Tax Relief and Health Care Act of 2006. The ACA expanded the RAC program s scope to include managed Medicare and Medicaid claims, and required all states to establish programs to contract with RACs by 2011. Currently all states where our subsidiaries operate have RAC programs, and all their 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 approximately $235, $65 and $36 for the fiscal years ended June 30, 2013, 2012 and 2011, respectively.

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 are 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 subsidiaries 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 ACA 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.

SPECIALTY PHARMACY OPERATIONS

The Specialty Pharmacy Segment is operated through SunLink ScriptsRx, LLC (ScriptsRx), a wholly-owned subsidiary, and composed of four material service lines:

1. Retail Pharmacy Products and Services, consisting of pharmacy sales at our three distribution facilities in Louisiana and including complementary products such as uniforms, vitamins, supplements and nutritionals.

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, specialty hospitals, hospices, and correctional facilities;

3. 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, and 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 patients 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.

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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.

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

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 cost containment mandates under 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 out-of-pocket costs. Our ScriptsRx operations 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 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 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 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 plus 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.

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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 ScriptsRx specialty pharmacy operations or that ScriptsRx will be able to operate its 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 it operates, or may seek to operate, in particular or that ScriptsRx would be able to meet the qualifications to become a Part B CAP vendor either now or at any time in the future.

Competition

There are many companies which provide one or more of the healthcare operations which comprise or may compete with our specialty pharmacy operations of ScriptsRx. 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 Omnicare, Inc. and PharMerica Corporation.

Healthcare Regulation

Overview

The healthcare industry is governed by an extremely complex framework of federal, state and local laws, rules and regulations, and 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

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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 or 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 subsidiaries currently operate hospitals (Georgia, Mississippi and Missouri) have CON laws that apply to such facilities. The two states (Georgia and Mississippi) in which SunLink subsidiaries 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.

SunLink is unable to predict whether its subsidiaries 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. In addition, future healthcare facility acquisitions also may occur in states that require CONs.

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 subsidiaries currently operate 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

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 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

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital s emergency department for treatment and, if the patient is suffering from an emergency medical condition or is in active labor, 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

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against that other hospital. Although we believe that our subsidiaries hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and whether our subsidiaries hospitals will be able to comply with any new requirements.

Specialty Pharmacy Segment Regulation

Overview

Much like our subsidiaries healthcare facility operations, the operations of our Specialty Pharmacy Segment subsidiary 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 its specialty pharmacy business as currently conducted, a failure to have the necessary permits and licenses could have a material adverse effect on its specialty pharmacy business, and our financial condition or results of operations.

Mail Order Activities

ScriptsRx conducts the operations of our Specialty Pharmacy Segment. In addition to walk-in customers at its retail centers, it distributes pharmaceuticals through a variety of delivery methods, including by mail and express delivery services. Many states in which ScriptsRx 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 ScriptsRx s operations, we believe its 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 ScriptsRx specialty pharmacy operations, they could have an adverse effect on its 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. 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.

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Healthcare Regulations of General Application

Licensing Requirements

Healthcare operations are subject to extensive federal, state and local licensing requirements. In order for our subsidiaries healthcare facilities to maintain their operating licenses, such healthcare facility operations must comply with strict standards concerning medical care, physical plant, equipment and hygiene. Various licenses and permits also are required in order to 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 the hospital operating subsidiaries operates only a single hospital. SunLink s four subsidiary owned hospitals are fully accredited by the JCAHO.

Drugs and Controlled Substances

Various licenses and permits are required by our subsidiaries healthcare facilities and by ScriptsRx s specialty pharmacy business in order to dispense narcotics and operate pharmacies. All of our subsidiaries 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 (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 also must 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 improper or excess payments; 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 Office of the Inspector General (OIG) of the United States 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 Department of Health and Human Services (HHS) and details the areas that the OIG believes are prone to fraud and abuse.

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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 programs, such as Medicare and Medicaid. Pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, HHS 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 OIG, 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 and to reinterpret 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

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healthcare providers are encouraged to disclose potential violations of the Stark Act to CMS. It is likely that self-disclosure of Stark Act violations will increase 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.

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 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 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 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 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 SunLink and our subsidiaries 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 limited history of enforcement efforts by the federal government at this time, it is difficult 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 subsidiaries 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 subsidiaries facilities and require compliance with rules governing

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the use and disclosure of such health information, and they require our subsidiaries 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 subsidiaries facilities. In addition, our subsidiaries 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.

The HIPAA privacy regulations also require healthcare providers to implement and enforce privacy policies to ensure compliance with the regulations and standards. 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 are presented to all employees and physicians at each facility. We believe all of our subsidiaries facilities 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 HHS 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 HHS 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 subsidiaries 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.

In conjunction with a consortium of rural hospitals, private HIPAA security consultants and HIPAA security officers at each facility, our subsidiaries 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, our subsidiaries developed and adopted an individually tailored comprehensive disaster contingency plan for each facility and presented a HIPAA security training program to all applicable personnel. We believe SunLink and our subsidiaries are in compliance with all aspects of the HIPAA security regulations.

HIPAA National Provider Identifier

HIPAA also required HHS 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 implemented use of a standard unique healthcare identifier by utilizing their employer identification number. HHS 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

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whether our facilities may experience payment delays during the transition to the new identifiers. HHS 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.

ICD-10 Coding System

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HHS has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In January 2009, CMS published a final rule regarding updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets and related changes to the formats used for certain electronic transactions. While use of the ICD-10 code sets is not mandatory until October 1, 2014, our subsidiaries are modifying payment systems and processes to prepare for the implementation. The ICD-10 code sets require significant administrative changes. We believe that the cost of compliance with these regulations has not had a material adverse effect on our cash flows, financial position or results of operations. The Health Reform Law requires HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

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. Based on our current level of operations, we do not anticipate that such compliance costs will have a material adverse effect on our cash flows, financial position or results of operations.

Regulatory Compliance Program

Our subsidiaries maintain a compliance programs under the direction of a risk manager. The 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 the subsidiary 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 its *Code of Conduct* and monitors its compliance program to respond to developments in healthcare regulations and the industry. A toll-free hotline is also maintained to permit employees to report compliance concerns on an anonymous basis.

Professional Liability

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

The recorded liability for professional liability risks of our subsidiaries operations includes an estimate of liability for claims assumed at the acquisition and for claims incurred after the acquisition of healthcare businesses. These estimates are based on actuarially determined amounts.

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Environmental Regulation

We believe our subsidiaries 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.

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EXECUTIVE OFFICERS OF THE REGISTRANT

Our executive officers, as of September 27, 2013, 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	64
Mark J. Stockslager	Chief Financial Officer and Principal Accounting Officer	54
Byron D. Finn	President SunLink ScriptsRx, LLC	63
Jack M. Spurr, Jr.	Vice President, Hospital Financial Operations	68

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 Officer 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.

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 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. Mr. Spurr s position is being eliminated effective October 1, 2013. Mr. Spurr has announced his retirement effective September 30, 2013.

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:

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Consolidated Operations Risks

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 subsidiary based limited 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 reduced Federal and state reimbursements, uncollectible self-pay net revenues of our Healthcare Facilities Segment, increased salary 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.

SunLink may require additional debt or equity capital in order to make significant capital investments or expand our operations and the inability to make significant capital investments or expand our operations may negatively affect SunLink s competitive position, reduce earnings, and negatively affect our results of operations.

SunLink s operations strategy requires 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 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 likely would be dilutive to shareholders. The failure to obtain funds necessary for the realization of SunLink s operating strategy could impair SunLink s existing operations and could force SunLink to forego opportunities that may arise in the future. This could, in turn, have a negative impact on the competitive position of our operating subsidiaries.

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

For the fiscal year ended June 30, 2013, our two Georgia hospitals generated approximately 52% 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.

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;

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ownership, condition and operation 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 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.

HHS 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 subsidiaries 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 subsidiaries 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, including discontinued healthcare operations.

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SunLink has discontinued operations carried on by its former life sciences and engineering segment and certain of our healthcare operations. SunLink currently does not purchase insurance policies to reduce 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.

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 ACA contains a number of provisions intended to promote value-based purchasing. Effective July 1, 2011, the ACA prohibits 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 ACA also requires HHS to implement a value-based purchasing program for inpatient hospital services. The Affordable Care Act requires HHS 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. HHS will pool the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by HHS. HHS will determine the amount each of our subsidiaries 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 adversely affect our cash flows, financial position, or results of operations.

The United States economy recently experienced a major economic recession, the economy remains relatively weak, unemployment levels remain high, and there is a substantial risk that the economy could lapse back into recession. Much healthcare spending is discretionary and can be significantly impacted by economic downturns. 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. In addition, employers may impose or patients may select 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 are unable to quantify the specific impact of recent or continued adverse economic conditions on our business; however we believe that the lingering effects of the economic recession have had an adverse impact on our operations. Such impact can be expected to continue to affect not only the healthcare decisions of our

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patients and potential patients but could also have an adverse impact on the solvency of certain managed care providers and other counterparties to transactions with us.

Our subsidiaries are 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.

Our subsidiaries are subject to potential claims for professional liability (medical malpractice) in connection with current operations, as well as potentially acquired or discontinued operations. To cover such claims, professional malpractice liability insurance and general liability insurance is maintained in amounts believed to be sufficient for 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 a 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 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 subsidiaries 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 hospital subsidiaries ability to maintain good relationships with the physicians and, if a hospital is unable to successfully maintain good relationships with physicians, admissions and outpatient revenues may decrease and operating performance could decline.

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

SunLink depends heavily on its subsidiaries 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.

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

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

In addition to the physicians and management personnel whom each subsidiary s hospital employs, hospital 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

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generally employees of an individual subsidiaries hospital. Each subsidiary s hospital s success has been, and will continue to be, influenced 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 a hospital s operating performance to decline.

A significant portion of SunLink s revenue is dependent on Medicare and Medicaid payments to its subsidiaries 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 consolidated revenues are derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. Approximately 87.0% of consolidated patient days and 56.6% of consolidated net patient revenues were derived from the Medicare and Medicaid programs for the year ended June 30, 2013. 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 our consolidated business, financial condition, results of operations or prospects.

Revenue and profitability of our subsidiaries healthcare facility operations, especially our community hospital operations, may be constrained by future cost containment initiatives undertaken by purchasers of healthcare services.

Our subsidiaries 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. Our community hospital operations derived approximately 43% of their consolidated net patient revenues for the fiscal year ended June 30, 2013 from private payors and other non-governmental sources who contributed approximately 13% of consolidated patient days. 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 subsidiaries admissions and outpatient revenues and have resulted in reduced revenue growth at our subsidiaries 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 our subsidiaries, specifically our hospital subsidiaries, are unable to contain costs 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 subsidiaries, especially community hospital subsidiaries, face intense competition from other hospitals and healthcare providers which directly affect our segment and consolidated revenues and profitability.

Although each of our subsidiaries hospitals operates in communities where they are currently the only general, acute care hospital, they face substantial 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.

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The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Each of our subsidiaries hospitals operates in geographic areas where they compete with at least one other hospital that provides comparable services. Some of these competing facilities offer services, including extensive medical research and medical education programs, which are not offered by SunLink s subsidiaries 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 subsidiaries 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 subsidiaries community hospitals, as well as their and our revenues and profitability.

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

Some of our subsidiaries 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 subsidiaries 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 subsidiaries hospitals are and 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 subsidiaries currently operate hospitals and nursing homes have laws requiring approval for the purchase, construction or expansion of various healthcare facilities including hospitals, nursing homes and ambulatory surgery centers and the provision of various services. Under such certificate of need (CON) 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 failure to obtain any required CON may impair SunLink s subsidiaries ability to operate profitably.

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

If our subsidiaries hospitals fail to effectively and timely implement electronic health record systems and transition to the ICD-10 coding system, our consolidated operations could be adversely affected.

As required by ARRA, HHS has adopted an incentive payment program for eligible hospitals and healthcare professionals that implement certified EHR technology and use it consistently with meaningful use requirements. If our subsidiaries hospitals and employed or contracted professionals do not meet the Medicare or Medicaid EHR incentive program requirements, their hospitals and clinics will not receive Medicare or Medicaid incentive payments to offset some of the costs of implementing the EHR systems. Further, beginning in federal fiscal year 2015,

eligible hospitals and physicians that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Failure to implement EHR systems effectively and in a timely manner could have a material, adverse effect on our consolidated financial position and results of operations.

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Health plans and providers, including our subsidiaries hospitals, are required to transition to the new ICD-10 coding system, which greatly expands the number and detail of billing codes used for inpatient claims. Under current regulations, use of the ICD-10 system is required beginning October 1, 2014. Transition to the new ICD-10 system requires significant investment in coding technology and software as well as the training of staff involved in the coding and billing process. In addition to these upfront costs of transition to ICD-10, it is possible that our subsidiaries hospitals could experience disruption or delays in payment due to technical or coding errors or other implementation issues involving systems or the systems and implementation efforts of health plans and their business partners.

Risks 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, 2013, the operation by ScriptsRX of our Specialty Pharmacy Segment derived approximately 51% 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 ScriptsRx or that ScriptsRx 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 ScriptsRx operates, or may seek to operate, in particular or that ScriptsRx would be able to meet the qualifications to become a Part B CAP vendor either now or at any time in the future.

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, 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 pharmacy services or changes in regulations governing such reimbursements could materially and adversely affect our pharmacy business, financial condition and results of operations.

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

Although ScriptsRx is 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 consolidated results of operations.

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

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 distributed by ScriptsRx are in short supply for long periods of time, this could result in a material adverse effect on our business and results of operations.

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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 the business of ScriptsRx.

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 the business of ScriptsRx and our consolidated results of operations. The largest supplier for ScriptsRx accounted for approximately 79% of Carmichael s cost of goods sold in the fiscal year ended June 30, 2013. Our specialty pharmacy operations have a single source of supply for many of our key products, including one product which accounted for approximately 27% of the segment s cost of goods sold in the fiscal year ended June 30, 2013. In addition, ScriptsRx has few long-term contracts with its suppliers. Arrangements with most of its suppliers may be canceled by either party, without cause, on minimal notice and many of these arrangements are not governed by written agreements.

The loss of one or more of 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 its institutional pharmacy customers. Significant declines in the level of purchases by one or more of the larger institutional pharmacy customers could have a material adverse effect on the business of ScriptsRx and our consolidated results of operations.

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

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. ScriptsRx also has 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.

ScriptsRx faces 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.

Large national companies operate in the existing market in which our Specialty Pharmacy Segment operates. 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.

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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 ScriptsRx is 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 Medicaid on a timely basis, at what rates or at all. Adverse developments in any of these areas could have an adverse impact on the business operations of our Specialty Pharmacy Segment.

The profitability of our Specialty Pharmacy Segment can be adversely affected by a decrease in the introduction of new brand name and generic prescription drugs.

Sales and profit margins of ScriptsRx are materially affected by the introduction of new brand name and generic drugs. New brand name drugs can result in increased drug utilization and associated sales revenues, while the introduction of lower priced generic alternatives typically result in relatively lower sales revenues, but higher gross profit margins. Accordingly, a decrease in the number of significant new brand name drugs or generics successfully introduced could adversely affect its results of operations.

Other Risks

Future developments could affect our ability to maintain adequate liquidity. Additionally, our ability to access alternative sources of capital is limited.

Historically our available capital has been sufficient to meet our operating expenses, lease obligations, debt service requirements, and capital expenditures and we have managed our liquidity such that our aggregate unrestricted cash at June 30, 2013, was $2,497 and our Trace hospital subsidiary has a $1,000 revolving line of credit (of which $0 was drawn as of June 30, 2013). Future circumstances could require us to materially increase our revenues, materially reduce our expenses, or otherwise materially improve operating results, dispose of existing assets or obtain material new sources of capital in order to maintain adequate liquidity.

The Company is currently limited in its ability to raise capital, debt or equity, in the public or private markets on what it considers acceptable terms, although it is actively seeking options to provide financing for the Company s liquidity needs. Three of the Company s subsidiaries have been able to borrow money through facility based mortgages, each of which is guaranteed by the Company, utilizing USDA Rural Development Authority guaranties, (individually, an RDA Loan and collectively, the RDA Loans), and, in the case of our Trace hospital subsidiary, obtain a working revolving capital loan facility of $1,000. The Company and its subsidiaries currently must fund working capital needs from cash from operations or from the sale of additional assets, and we cannot assure you that we would be successful in improving our results of operations, reducing our costs, obtaining additional credit facilities or selling additional assets.

If we go private, holders of our securities will be subject to the risks of an investment in a private rather than a public company.

In the event the Company is able to deregister its common stock under the Exchange Act, holders of our securities will be subject to the risks of an investment in a private rather than a public company. We cannot tell you when or if the Company will be entitled to deregister. Upon any deregistration of our shares, our duty to file periodic reports with the SEC will be suspended for as long as we have fewer than 300 record shareholders, and we will no longer be a public reporting company. In addition, we will be relieved of the obligation to comply with the requirements of the proxy rules under Section 14 of the Exchange Act. When and if the Company is able

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to deregister, SunLink shares will no longer be listed on the NYSE Amex Equities stock exchange, and there may not be a sufficient number of shares outstanding and publicly traded following any deregistration to ensure a continued trading market in the shares in any over-the-counter market. The continued quotation of our common shares as well as the availability of any over-the-counter trading in our common shares will depend, in part, on the nature and extent of continued publicly available information about SunLink. Shareholders also could be adversely affected by a reduction in our public float, that is, the number of shares owned by outside shareholders and available for trading in the securities markets, especially if the Company makes future tender offers or private or open market purchases of its common shares. The suspension of our reporting obligations under the Exchange Act may further reduce the existing limited trading market for the Company s shares and may result in a decline in the price of the Company s shares and reduced liquidity in any trading market for our shares in the future. We may also have less access to capital markets and not be able to use the Company s shares to effect acquisitions as a non-reporting company.

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.

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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
Medical Office of North Georgia and Community Center of North Georgia (1)	Ellijay, GA	N/A	October 31, 2013	Owned
Specialty Pharmacy Operations				
ScriptsRx (2)	Crowley, LA	N/A	April 22, 2008	Leased
ScriptsRx (3)	Lafayette, LA	N/A	April 22, 2008	Leased
ScriptsRx (4)	Lake Charles, LA	N/A	April 22, 2008	Leased
Other				
Careside Medical Park (5)	Clanton, AL	N/A	February 1, 2001	Owned
Corporate Offices (6)	Atlanta, GA	N/A	June 1, 1998	Leased

(1) Lease of approximately 47,500 combined square feet of medical office building and community center. The lease expires in October 2037 and is leased to a SunLink subsidiary.
(2) Lease of approximately 25,000 square feet of store location, warehouse and office space. The lease expires in April 2018 and provides for a renewal of the lease for one five-year term. Additional lease, commencing April 2013, of approximately 1,300 square feet of office space. This lease expires in April 2014 and provides for renewal of the lease for additional one-year and three-year terms.
(3) Lease of approximately 5,900 square feet of store location and warehouse space. The lease expires in October 2014.
(4) Lease of approximately 7,800 square feet of store location and warehouse space. The lease expires in December 2013 and provides for a renewal of the lease for one five-year term.
(5) The 62,013 square-foot hospital building is being repurposed as a multi-tenant medical park.
(6) Lease of approximately 4,800 square feet of office space for corporate staff. The lease expires in March 2015.

Item 3. ***Legal Proceedings***

In 2007, Southern Health Corporation of Ellijay, Inc. (SHC-Ellijay) 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 and the defendants filed counterclaims against SHC-Ellijay.

On April 11, 2012, the Court granted SHC-Ellijay s motion for partial summary judgment and denied Defendants motions for summary judgment. In April 2012, Defendants filed a notice of appeal to the Georgia Court of Appeals. In March 2013, the Georgia Court of Appeals issued an opinion affirming in part and reversing

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in part the summary judgment entered for the Company. The appellate court rejected all of the Sellers various contract-law defenses. The appellate court also held that the Sellers intentionally breached the Option Agreement by failing to close the transaction and satisfy their other obligations. The appellate court reversed, however, on the question of whether Sellers breach was also willful, reasoning that willfulness carries with it an aspect of bad faith. The case has been remanded to the Superior Court for trial on the willfulness/bad faith issue and damages. A trial has not yet been scheduled but could occur as early as March 2014.

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

SunLink and its subsidiaries are a party to various medical malpractice and other 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 but could have a material adverse effect on the financial position, cash flows, or results of operations of the Company. The Company expenses legal costs as they are incurred.

Office of Inspector General Investigation In March 2013, SunLink received a document subpoena from the United States Department of Health and Human Services Office of Inspector General (OIG) in connection with an investigation of possible improper claims submitted to Medicare and Medicaid. The subpoena was directed to SunLink s indirect subsidiary Southern Health Corporation of Dahlonega, Inc. (SHCD), which owns and operates Chestatee Regional Hospital in Dahlonega, Georgia, and requested documents concerning possible false or fraudulent claims made for intensive outpatient psychiatric services provided by and billed for a third-party outpatient psychiatric service provider. The subpoena also sought information about SHCD s relationship with the outpatient psychiatric service provider, including financial arrangements. SHCD is continuing to cooperate with the government with respect to an ongoing document production, as well as conducting a joint medical necessity review of a sampling of medical records. We cannot at this time estimate what, if any, impact these matters and any results from these matters could have on our business, financial position, operating results or cash flows.

Internal Revenue Service The Company is subject to examination of its income tax returns by the Internal Revenue Service (IRS) and other tax authorities. The Company s U.S. Federal income tax returns filed for the tax years ended June 30, 2009 through June 30, 2011 are under examination by the IRS. In May 2013, the Company received from the IRS a Notice of Proposed Adjustment (NOPA) primarily related to bad debts claimed by the Company in the tax year ended June 30, 2011. In September 2013, SunLink received a Revenue Agent Report (RAR) for the years ending June 30, 2009, June 30, 2010, and June 30, 2011. The RAR has not been finalized and is still subject to internal review by the IRS. SunLink expects to agree to this RAR. As a result of the RAR, no additional cash taxes are expected to be due for these periods; however, net operating loss carryforward balances will be adjusted to offset any increase to taxable income resulting from the IRS examination for these periods. The financial statements have been adjusted to reflect the uncertain tax position under ASC 740-10 created as a result of the RAR.

Item 4. ***Reserved***

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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 2013 (July 1, 2012 - June 30, 2013)		
Fourth Quarter	$ 0.92	$ 0.71
Third Quarter	1.26	0.56
Second Quarter	1.55	0.90
First Quarter	1.56	0.95
Fiscal 2012 (July 1, 2011 - June 30, 2012)		
Fourth Quarter	$ 1.29	$ 0.86
Third Quarter	1.67	0.97
Second Quarter	2.00	1.64
First Quarter	2.20	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 for other corporate purposes 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.

Holders

As of June 30, 2013 there were approximately 475 registered holders of SunLink common shares.

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Securities Authorized for Issuance under Equity Compensation Plans

The following provides tabular disclosure of the number of securities at June 30, 2013 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	37,500	$ 2.42	0
2005 Equity Incentive Plan	369,999	3.43	360,676
2011 Director Stock Option Plan	210,000	1.37	90,000
	617,499	$ 1.92	450,676
Equity compensation plans not approved by security holders:			
None	0	0	0
Total	617,499	$ 1.92	450,676

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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., 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.

*$100 invested on 6/30/08 in stock or index, including reinvestment of dividends.

Fiscal year ending June 30.

	6/08	6/09	6/10	6/11	6/12	6/13
SunLink Health Systems, Inc.						