SUNLINK HEALTH SYSTEMS INC
Form 10-K/A
May 21, 2012
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

Form 10-K/A

(Amendment No. 1)

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

For the Fiscal Year Ended June 30, 2011

OR

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

For the transition period from to

Commission File No. 1-12607

SunLink Health Systems, Inc.

(Exact name of registrant as specified in its charter)

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

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

(Address of principal executive offices)

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

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

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

Indicate by check mark whether if the registrant is a well-known seasoned issuer, as defined in Rule 405 of 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 May 21, 2012, there were 9,447,949 shares of the registrant s common shares without par value outstanding. The aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the closing price on December 31, 2010 of the registrant s common shares as reported by NYSE Amex Equities stock exchange amounted to $7,323,000.

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EXPLANATORY NOTE

UPDATE

This Form 10-K/A amends the Annual Report on Form 10-K for the fiscal year ended June 30, 2011 (the **Original 10-K**) of SunLink Health Systems, Inc. (**we** , **our** , **us** , **SunLink** or the **Company**) filed with the Securities and Exchange Commission (the **SEC**) on September 27, in response to comments issued by the SEC and to clarify certain prior disclosures. This Form 10-K/A contains changes to the Cover Page; Part I Item 1 (Business); Part I Item 6 (Selected Financial Data); Part II Item 7 (Management s Discussion and Analysis of Financial Condition and Results of Operations); Part II Item 8 (Financial Statements and Supplementary Data); Part II Item 9A (Controls and Procedures) and Part IV Item 15 (Exhibits, Financial Statement Schedules). In an unrelated matter, this Form 10-K/A also reflects the retroactive reclassification of financial information with respect to the reclassification of the Company s Memorial Hospital of Adel and Memorial Convalescent Center (collectively, Adel) to discontinued operations (Discontinued Operations Reclassification) as a result of the Company s decision in the quarter ended March 31, 2012 to sell such operations and the entry by the Company and its HealthMont of Georgia, Inc. subsidiary, on March 8, 2012, into an Asset Purchase Agreement by and among HealthMont of Georgia, Inc., SunLink and Hospital Authority of Tift County, Georgia (Buyer) effective as of March 1, 2012 (the Adel Sale Agreement) to sell substantially all of the assets of Adel to the Buyer for approximately $8,300.

In accordance with Sections 302 and 906 of the Sarbanes-Oxley Act of 2002, currently dated certifications of the Company s principal executive officer and principal financial officer are attached to this Form 10-K/A as Exhibits 31.1, 31.2, 32.1 and 32.2, and the text of Exhibits 31.1 and 31.2 has been amended to reflect SEC comments. Part IV Item 15 has not been amended in any respect from the Original 10-K, except for the amended text of the aforementioned Exhibits.

Except for the foregoing amended information, the Company has not updated the disclosures contained in the Original 10-K to reflect events that have occurred subsequent to the filing date of the Original 10-K. Accordingly, this Form 10-K/A should be read in conjunction with the Original 10-K and our subsequent filings with the SEC.

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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

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

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

History

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

Business Strategy: Strategic Alternatives, Operations, Acquisitions and Dispositions

SunLink s business strategy is to focus its efforts on internal operations of its existing healthcare facilities and its pharmacy business, supplemented by growth from potential healthcare acquisitions, including but not limited to hospitals, physician clinics, ambulatory surgery centers, nursing homes and pharmacy businesses. However, as was the case in 2004 with our Mountainside Medical Center hospital, in September 2009 with the sale of three home health agencies and in March 2011 with the sale of our Clanton Hospital operations, we consider dispositions of one or more of our facilities or operations based on a variety of factors including asset values, return on investments, competition from existing and potential facilities, capital improvement needs, corporate strategy and other corporate objectives.

On April 8, 2011, SunLink Health Systems, Inc. announced that it has reached a preliminary agreement and executed a letter of intent with Foundation HealthCare Affiliates, LLC (Foundation) and New Age Fuel, Inc. (New Age), and Foundation Investment Affiliates I, LLC (FIA) for the non-cash merger of certain Foundation

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and New Age, FIA, subsidiaries and affiliates with and into newly formed acquisition subsidiaries of SunLink. The contemplated transaction is subject to a number of conditions, including completion of due diligence by each of the parties, negotiation and execution of a definitive merger agreement and consent of lenders. The subsidiaries and affiliates of Foundation contemplated to be merged into the SunLink acquisition subsidiaries per the letter of intent own minority equity interests in and manage 14 ambulatory surgery centers in seven states (Louisiana, Maryland, New Jersey, Ohio, Oklahoma, Pennsylvania and Texas), own a majority interest in and manage one general acute care hospital and manage a second acute care hospital, both of which are located in Texas. Three medical real properties, which are occupied by Foundation entities as well as other tenants in Oklahoma, are majority owned by New Age and FIA and would also be merged into the SunLink acquisition subsidiaries.

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

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

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

Upon completion of the mergers, the combined company would expect to change its name to Foundation SunLink Healthcare Affiliates, Inc. In addition, it is anticipated that two persons designated by Foundation/New Age will join the board of directors of SunLink. Foundation SunLink is intended to be a premier healthcare facilities company positioned to respond to the changing marketplace developing under healthcare reform. Foundation SunLink s mission will be to more closely align the interests of physicians, hospitals and related healthcare facilities to improve the quality of care and control healthcare costs in communities it serves. It is anticipated that Foundation SunLink will focus on growth through physician-centric hospitals, surgery centers and related ancillary service providers, including its existing hospitals and surgery centers, plus the aggressive acquisition and development of additional physician-centric hospitals, surgery centers and ancillary service providers nationwide. No definitive agreement was executed in relation to the contemplated mergers.

On November 8, 2011, SunLink and Foundation announced that they had ended their previously announced merger discussions. SunLink s Board and management concluded that the business plan that the Company has adopted is fundamentally sound and has determined to focus the Company s strategic efforts on enhancing its existing hospital portfolio and on pursuing potential hospital acquisitions. SunLink is committed to enhancing shareholder value while maintaining high standards of responsibility to its patients, employees and the communities it serves and will continue to pursue strategic alternatives consistent with that commitment.

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On March 8, 2012, the Company and its HealthMont of Georgia, Inc. subsidiary entered into an Asset Purchase Agreement by and among HealthMont of Georgia, Inc., SunLink and Hospital Authority of Tift County, Georgia (Buyer) effective March 1, 2012 to sell substantially all of the assets of the Company s owned Memorial Hospital of Adel and Memorial Convalescent Center (Adel) to the Buyer for approximately $8,300. Excluded assets include accounts receivable as of the Cutoff Date and all Medicare and Medicaid incentive payments for meaningful use of electronic health record technology and all receivables, claims and settlements made pursuant to the Indigent Care Trust Fund of the State of Georgia, in each case, paid with respect to the fiscal year ending June 30, 2012. Retained liabilities generally consist of liabilities incurred prior to the closing date of the transaction. Effective April 1, 2012, Buyer began management of Adel under a management agreement to continue from such date until the scheduled date of closing. The Buyer is to retain any profit earned and fund any losses incurred during the management period. The transaction is subject to a number of conditions and is expected to close in SunLink s first fiscal quarter of 2013. The agreement may be terminated by either SunLink or the Buyer if the transaction is not consummated prior to July 31, 2012 or such later date as the parties may agree. Subject to certain conditions, if the Buyer terminates the agreement during the period April 1, 2012 through July 31, 2012 from other than a default by the Company, SunLink will be entitled to a breakup fee of $900. SunLink anticipates that the sale of assets of Adel for approximately $8,300, less estimated sale expenses, will result in net proceeds of approximately $7,500 to the Company and that the Company will be required to use all or substantially all of the net proceeds to pay down senior debt under the Company s Credit Facility.

Operations Strategy

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

Acquisition and Disposition Strategy

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

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

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

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

Historically, we targeted the rural or exurban community hospital market because we believed it provided an attractive sector for investment in healthcare facilities. We continue to believe hospitals and other healthcare businesses in our markets generally experience (1) less direct competition, (2) lower managed care penetration, (3) more manageable inflationary pressure with respect to certain costs, (4) higher staff, employee and community

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loyalty, and (5), in certain cases, opportunity for future growth. The focus of acquisition activities will depend on our evaluation of relative opportunities for growth and profitability within the business segments and services lines of our existing operations, the capital needs of our existing and potential operations within such existing and potential segments and services lines, current and potential changes in government regulation and reimbursement rules, competition for potential acquisitions and valuations of existing or potential new healthcare related facilities and operations and other factors.

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

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

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

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

As noted above, we currently have an agreement to sell Adel which we expect to close in the first fiscal quarter of 2013. From time to time we may consider the additional dispositions of one or more of our healthcare facilities, service lines or business segments, particularly if we determine that the operating results or potential growth of such facility, service line or segment no longer meet our business objectives.

Healthcare Facilities Operations

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

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

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

Through our subsidiaries, we operate a total of five community hospitals in three states. Four of the community hospitals are owned and one is leased. SunLink s community hospitals are acute care hospitals and have a total of 282 licensed beds. We also own one 60 licensed bed hospital building that is leased to a third party with an option to purchase at the end of the lease. In connection with our community hospital operations in certain communities, we also operate (a) two nursing homes located in two states: each of our current nursing homes is located adjacent to our community hospitals, and (b) one home healthcare agency operated from one of our community hospitals. Our nursing homes have a total of 166 licensed beds.

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Owned and Leased Hospitals

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

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

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

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

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

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

We also own Memorial Hospital of Adel, located in Adel, Cook County, Georgia, which is a JCAHO accredited 60-licensed-bed, acute-care hospital and Memorial Convalescent Center, which is a 95-bed skilled nursing facility. Memorial Hospital of Adel is the only hospital in Cook County. As discussed above, we have an agreement to sell both the hospital and the nursing facility and we currently expect to close such sale in the first fiscal quarter of 2013. We also own the Chilton Medical Center (Chilton) hospital building located in Clanton, Chilton County, Alabama which we lease to a third party. Chilton is a 60-licensed-bed, JCAHO accredited, acute-care hospital. The third party has the option to purchase the facility. Chilton is the only hospital in Chilton County.

Hospital Operations

Utilization of Local Hospital Management Teams

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

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

Each hospital management team is responsible for the day-to-day operations of its hospital. Our corporate staff provides support services, assistance, and advice to each hospital in certain areas, including strategic planning,

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physician recruiting and relationship management, corporate compliance, reimbursement, information systems, human resources, accounting, cash management, capital financing, tax and insurance. Financial controls are maintained through the utilization of standardized policies and procedures and monitoring by corporate staff. Our hospitals have contracted with the HealthTrust Group Purchasing Organization, a purchasing group used by a large number of community hospitals, for certain supplies and equipment. We promote communication among our hospitals and management teams so that local expertise and improvements can be shared among all of our facilities.

Expansion of Services and Facilities

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

Medical Staff

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

Physician Recruiting

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

Quality Assurance

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

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Operating Statistics

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

	Fiscal Years Ended June 30,		
	2011 (restated)	2010	2009
Hospitals owned or leased at end of period	5	5	5
Licensed hospital bed (at end of period)	282	282	282
Hospital beds in service (at end of period)	223	223	223
Nursing home beds in service (at end of period)	166	166	166
Admissions	5,226	5,814	6,393
Equivalent Admissions (1)	16,118	17,511	17,477
Average Length of Stay (2)	3.5	3.6	3.5
Patient days	18,521	21,073	22,635
Adjusted patient days (3)	56,270	62,288	60,895
Occupancy rate (% of licensed beds)(4)	17.99%	20.47%	21.99%
Occupancy rate (% of beds in service)(5)	22.75%	25.89%	27.81%
Net patient service revenues (in thousands)	$ 114,460	$ 123,712	$ 116,831
Net outpatient service revenues (in thousands)	$ 52,712	$ 61,476	$ 57,610
Net revenue per equivalent admissions	$ 7,101	$ 7,065	$ 6,685
Net outpatient service revenues (as a % of net patient service revenues)	46.05%	49.69%	49.31%

As discussed in Note 1. Basis of Presentation and Restatement, in the Notes to the consolidated financial statements, we have restated our previously issued financial statements for the fiscal year ended June 30, 2011; accordingly, all amounts in the table have been adjusted to the extent required by such restatement.

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

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

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

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

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

Sources of Revenue

Each SunLink hospital receives payments for patient care from Federal Medicare programs, State Medicaid programs, private insurance carriers, health maintenance organizations, preferred provider organizations, TriCare, and from employers and patients directly. Medicare is a Federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a Federal-state program, administered by the states, that provides hospital and nursing home benefits to

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qualifying individuals who are unable to afford care. All of SunLink s hospitals are certified as healthcare services providers for persons covered by Medicare and Medicaid programs. TriCare is a Federal program for the healthcare of certain U.S. military personnel and their dependants. See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations .

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

	Fiscal Years Ended June 30,		
	2011	2010	2009
Source			
Medicare	72.9%	73.0%	73.1%
Medicaid	10.2%	9.3%	8.1%
Private and Other Sources	16.9%	17.7%	18.8%
	100.0%	100.0%	100.0%

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

	Fiscal Years Ended June 30,		
	2011	2010	2009
Source			
Medicare	40.9%	38.9%	39.5%
Medicaid	12.6%	11.6%	14.5%
Private and Other Sources	46.5%	49.5%	46.0%
	100.0%	100.0%	100.0%

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

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

Competition

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

The appearance and functionality of the healthcare facilities;

The quality and demeanor of professional staff and physicians; and

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

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

Managed Care

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

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

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

Efforts to Control Healthcare Costs

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

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the Affordable Care Act or ACA) were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. The ACA dramatically alters the United States health care system and is intended to decrease the number of uninsured Americans and reduce overall health care costs. The ACA attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, including disproportionate share payments,

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expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The ACA also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. Because a majority of the measures contained in the ACA do not take effect until 2013 and 2014 and most of the rules and regulations that implement the provisions of the ACA have not been adopted or proposed, it is difficult to predict the impact the ACA will have on our facilities. However, it is possible that the implementation or interpretation of such rules and regulations or the provisions of the ACA could have an adverse effect on our financial condition and results of operations.

Government Reimbursement Programs

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

Medicare Inpatient Reimbursement

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

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

DRG rate increases were 2.1% and 2.35% for Federal fiscal years (FFY) 2010 and 2011, respectively, and currently is 1.1% for FFY 2012. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future Federal fiscal years at rates that would be based on the market basket index, which in certain years have been, and in the future may be, subject to reduction factors. In FFY 2012 the market basket rate currently is affected by two such reduction factors. First as required by the Affordable Care Act, the market basket rate is reduced by 0.25%. Second, CMS is applying a documentation and coding adjustment to recoup a portion of excess aggregate payments in FFY 2008 and FY 2009 that did not reflect actual increases in patients severity of illness. Under legislation passed in 2007, CMS is required to recoup the entire amount of FFY 2008 and 2009 excess spending resulting from changes in hospital coding practices no later than FFY 2012. If the update factor does not adequately reflect increases in SunLink s cost of providing inpatient services, our financial condition or results of operations could be negatively affected.

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

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

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

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

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

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

Medicare Outpatient Reimbursement

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

Medicare Bad Debt Reimbursement

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

Bad debts must meet the following criteria to be allowable:

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

the debt was actually uncollectible when claimed as worthless; and

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

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

Medicare Disproportionate Share Payments

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

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Medicaid Inpatient and Outpatient Reimbursement

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

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

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

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

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

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

In 2006, Georgia implemented a Medicaid HMO program and awarded contracts to private companies for the management and processing of certain Medicaid claims. The intent of the Medicaid HMO program is to curtail utilization and reduce rates paid by the State of Georgia. All of SunLink s facilities that operate in the state of Georgia have secured contracts with all the HMO companies contracted by the state in their respective regions. Since the implementation of the Medicaid HMO program, all SunLink hospitals receive reimbursement from three different contractors instead of a single source. While the amounts of the inpatient payments have not changed since the contractors utilize the same payment rates, the timing of the receipt of the payments has changed due to the multiple payors. For outpatient services, our hospitals have contracts with the three HMO vendors and services are reimbursed at 102% of the current interim rate as determined by the Georgia Department of Community Health.

Adoption of Electronic Health Records

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 the American Recovery and Reinvestment Act of 2009 (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 and critical access hospitals (CAH) 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.

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The Company accounts for EHR incentive payments in accordance with ASC 450-30, Gain Contingencies (ASC 450-30). In accordance with ASC 450-30, the Company recognizes a gain for EHR incentive payments when its eligible hospitals have 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 Centers for Medicare and Medicaid Services.

Attestation of Medicare meaningful use requirements for the first year (October 1, 2010 September 30, 2011) began on April 18, 2011. Each of SunLink s five hospitals and its formerly owned Chilton Medical Center registered for the program with CMS and on April 18, 2011 all successfully attested compliance with Part I of the Medicare EHR incentive program for such first year. The Company has received $6,597 in EHR Medicare incentive reimbursements for the five hospitals and $790 for its formerly owned Chilton Medical Center for the fiscal year ended June 30, 2011.

The Company has also successfully attested to the meaningful use requirements for Medicaid program for its Mississippi hospital. The Company accrued Medicaid EHR reimbursement for Mississippi in the amount of $277. We intend to attest for EHR meaningful use under state Medicaid programs for Georgia and Missouri when the program are established by those states.

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

Government Reimbursement Program Administration and Adjustments

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

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

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

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

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

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

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

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

SPECIALTY PHARMACY OPERATIONS

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

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

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

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

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

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

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

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

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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.

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

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

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

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

Government Reimbursement Programs

Our Specialty Pharmacy Business is subject to certain rules implemented by the Medicare Modernization Act (MMA) and, in the future may be subject to other rules previously implemented by MMA with respect to urban providers. Regulations implementing the cost containment mandates under the MMA reduced the reimbursement for healthcare providers in urban areas for a number of products and services which are also provided by our pharmacy operations and established a competitive bidding program for certain durable medical equipment provided under Medicare Part B in urban areas. Competitive bidding is intended to further reduce reimbursement for certain products and will likely decrease the number of companies permitted to serve Medicare beneficiaries in the competitive bidding areas (CBAs). CMS had planned to implement the competitive bidding program for Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) products and services with the goal of offering beneficiaries access to quality with lower out-of-pocket costs. We were exempted under the Deficit Reduction Act of 2005 from the proposed competitive acquisition program for DMEPOS, but we cannot be sure such exemption will continue to be available in the future or that the program, if expanded in the future, would be expanded in its original form. If the program is expanded in the future, loss of the exemption could have an adverse effect on our financial condition or results of operation. The program has, however, been deferred indefinitely, and whether or not the program will be implemented in the future is unknown.

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

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

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

Section 303(d) of the MMA also requires the implementation of a competitive acquisition program (the Part B CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The Part B

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CAP is an alternative to the ASP methodology for acquiring certain Part B drugs which are administered incident to a physician s services. Currently, the Part B CAP is a voluntary program that offers physicians the option to acquire many injectable and infused drugs they use in their practice from an approved Part B CAP vendor, thus reducing the time and cost of buying and billing for drugs. Currently, the CAP for Part B Drugs and Biologicals is only for injectable and infused drugs currently billed under Part B that are administered in a physician s office, incident to a physician s service.

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

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

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

Competition

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

Healthcare Regulation

Overview

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

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

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

Healthcare Facility Regulation

Certificate of Need Requirements

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

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

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

Utilization Review Compliance and Hospital Governance

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

Emergency Medical Treatment and Active Labor Act

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

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Conversion Legislation

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

Specialty Pharmacy Segment Regulation

Overview

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

Mail Order Activities

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

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

Advertising and Marketing Regulations

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

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Healthcare Regulations of General Application

Licensing Requirements

SunLink s healthcare operations are subject to extensive Federal, state and local licensing requirements. In order to maintain their operating licenses, our healthcare facility operations must comply with strict standards concerning medical care, equipment and hygiene. Various licenses and permits also are required in order to handle radioactive materials and operate certain equipment. All licenses, provider numbers, and other permits or approvals required to perform our business operations are held by individual subsidiaries of SunLink. Each of our hospital operating subsidiaries operates only a single hospital. All of SunLink s hospitals, except the leased hospital in Dexter, Missouri, are fully accredited by the JCAHO.

Drugs and Controlled Substances

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

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

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

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

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

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

Sections of the Anti-Fraud and Abuse Amendments to the Social Security Act, commonly known as the anti-kickback statute, prohibit certain business practices and relationships that might influence the provision and cost of healthcare services reimbursable under Medicare, Medicaid,

TriCare or other healthcare programs, including the payment or receipt of remuneration for the referral of patients whose care will be funded by Medicare or other government programs. Sanctions for violating the anti-kickback statute include criminal penalties and civil sanctions, including fines and possible exclusion from future participation in government programs, such as

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

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

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

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

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

The Federal False Claims Act and Similar State Laws

The federal False Claims Act prohibits providers from, among other things, knowingly submitting false or fraudulent claims for payment to the federal government. The federal False Claims Act defines the term knowingly broadly, and while simple negligence generally will not give rise to liability, submitting a claim with reckless disregard to its truth or falsity can constitute the knowing submission of a false or fraudulent claim for the

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

HIPAA Transaction, Privacy and Security Requirements

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

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

HIPAA Privacy Regulations

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

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

HIPAA Electronic Data Standards

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for all healthcare related electronic data interchange. These provisions are intended to streamline and encourage electronic commerce in the healthcare industry. Among other things, these provisions

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require healthcare facilities to use standard data formats and code sets established by the DHHS when electronically transmitting information in connection with certain transactions, including health claims and equivalent encounter information, healthcare payment and remittance advice and health claim status.

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

HIPAA Security Standards

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

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

HIPAA National Provider Identifier

HIPAA also required DHHS to issue regulations establishing standard unique health identifiers for individuals, employers, health plans and healthcare providers to be used in connection with standard electronic transactions. All healthcare providers, including our facilities, were required to obtain a new National Provider Identifier (NPI) to be used in standard transactions instead of other numerical identifiers by May 23, 2007. Our facilities have fully implemented use of a standard unique healthcare identifier by utilizing their employer identification number. DHHS has not yet issued proposed rules that establish the standard for unique health identifiers for health plans or individuals. Once these regulations are issued in final form, we expect to have approximately one to two years to become fully compliant, but cannot predict the impact of such changes at this time. We cannot predict whether our facilities may experience payment delays during the transition to the new identifiers. DHHS is currently working on the standards for identifiers for health plans; however, there are currently no proposed timelines for issuance of proposed or final rules. The issuance of proposed rules for individuals is on hold indefinitely.

Medical Waste Regulations

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

SUNLINK OPERATIONS

Regulatory Compliance Program

SunLink maintains a company-wide compliance program under the direction of the Director of Reimbursement and Compliance. SunLink s compliance program is directed at all areas of regulatory compliance, including physician recruitment, reimbursement and cost reporting practices, as well as pharmacy and home healthcare operations. Each hospital designates a compliance officer and develops plans to correct problems should they arise. In addition, all employees are provided with a copy of and given an introduction to SunLink s *Code of*

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Conduct, which includes ethical and compliance guidelines and instructions about the proper resources to utilize in order to address any concerns that may arise. Each hospital conducts annual training to re-emphasize SunLink s *Code of Conduct*. We monitor our corporate compliance program to respond to developments in healthcare regulations and the industry. SunLink also maintains a toll-free hotline to permit employees to report compliance concerns on an anonymous basis.

Professional Liability

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

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

Environmental Regulation

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

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EXECUTIVE OFFICERS OF THE REGISTRANT

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

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

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

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

Mark J. Stockslager has been Chief Financial Officer of SunLink Health Systems, Inc. since July 1, 2007. He was interim Chief Financial 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.

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

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

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

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PART II

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

As discussed in Note 1. Basis of Presentation and Restatement, in the Notes to the consolidated financial statements, we have restated our previously issued financial statements for the fiscal year ended June 30, 2011; accordingly, all amounts in the table have been adjusted to the extent required by such restatement.

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

SunLink Selected Historical Financial Data

(All amounts in thousands, except per share amounts)

	2011	2010	2009	2008	2007
Net Revenues	$ 154,380	$ 166,322	$ 162,961	$ 123,946	$ 112,998
Earnings (loss) from continuing operations	(15,416)	(422)	611	1,435	2,006
Net earnings (loss)	(16,103)	102	912	1,616	1,396
Earnings (loss) per share from continuing operations					
Basic	(1.90)	(0.05)	0.08	0.19	0.27
Diluted	(1.90)	(0.05)	0.08	0.18	0.26
Net earnings per share:					
Basic	(1.99)	0.01	0.11	0.21	0.19
Diluted	(1.99)	0.01	0.11	0.21	0.18
Total Assets	91,830	98,490	107,383	111,624	77,814
Long-term debt, including current maturities	31,752	33,437	35,545	37,963	8,534
Shareholders equity	$ 26,068	$ 42,692	$ 42,392	$ 40,244	$ 36,024

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

As discussed in Note 1. Basis of Presentation and Restatement, in the Notes to the consolidated financial statements in Item. 8, we have restated our previously issued financial statements for the fiscal year ended June 30, 2011; accordingly, Management s Discussion and Analysis of Financial Condition and Results of Operations have been revised for the effects of the restatement.

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

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achievements to differ materially from those anticipated, see Certain Cautionary Statements Forward Looking Information and Item 1A included in the Form 10-K for the fiscal year ended June 30, 2011 filed September 26, 2011.

Critical Accounting Estimates

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

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated statement of earnings or financial condition.

The table of critical accounting estimates that follows is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 2 of our Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K /A for the fiscal year ended June 30, 2011, the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and financial condition.

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

Balance Sheet or Income Statement		
Caption/Nature of Critical Estimate Item	**Assumption / Approach Used**	**Sensitivity Analysis**
(dollar amounts in thousands, except per share)	**(dollar amounts in thousands, except per share)**	**(dollar amounts in thousands, except per share)**
Receivables-net and Provision for Bad Debts		
Receivables-net for our Healthcare Facilities Segment primarily consists of amounts due from third-party payors and patients from providing healthcare services to hospital facility patients. Receivables-net for our Specialty Pharmacy Segment primarily consists of amounts due from third-party payors; institutions such as nursing homes, home health, hospice, hospitals; pharmacy stores; Medicaid Part D program; and customers from the sale of pharmacy services and merchandise. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. Our allowance for doubtful accounts, included in our balance sheets as of June 30 was as follows: 2011 $12,317; and 2010 $14,725.	The largest component of bad debts in our patient accounts receivable for our healthcare facilities and Specialty Pharmacy Segments relates to accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. In general, we attempt to collect deductibles, co-payments and self-pay accounts prior to the time of service for non-emergency care. If we do not collect these patient responsibility accounts prior to the delivery of care, the accounts are handled through our billing and collections processes. We attempt to verify each patient s insurance coverage as early as possible before a scheduled non-emergency admission or procedure, including with respect to eligibility, benefits and authorization/pre-certification requirements, in order to notify patients of the estimated amounts for which they will be responsible. We attempt to verify insurance coverage within a reasonable amount of time for all emergency room visits and non-emergency urgent admissions in compliance with the Emergency Medical Treatment and Active Labor Act.	A significant increase in our provision for doubtful accounts (as a percentage of revenues) would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and potentially our future access to capital. If net revenues during fiscal year 2011 were changed by 1%, our 2011 after-tax income from continuing operations would change by approximately $1,019 or diluted earnings per share of $0.15. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate uncollectible patient accounts that are highly uncertain and requires a high degree of judgment. It is impacted by, among other things, changes in regional economic conditions, business office operations, payor mix and trends in private and federal or state governmental healthcare coverage.

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Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item	Assumption / Approach Used	Sensitivity Analysis
(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)
Our provision for bad debts, included in our results of operations, was as follows : 2011 $16,841; 2010 $20,364; and 2009 $16,901 ***Receivables-net and Provision for Bad Debts (continued)***	In general, we utilize the following steps in collecting accounts receivable: if possible, cash collection of all or a portion of deductibles, co-payments and self-pay accounts prior to or at the time service is provided; billing and follow-up with third party payors; collection calls; utilization of collection agencies; sue to collect if the patient has the means to pay and chooses not to pay; and if collection efforts are unsuccessful, write off the accounts. Our policy is to write off accounts after all collection efforts have failed, which is typically no longer than 120 days after the date of discharge of the patient or service to the patient or customer. Patient responsibility accounts represent the majority of our write-offs. All of our hospitals retain third-party collection agencies for billing and collection of delinquent accounts. At most of our hospitals, more than one collection agency is used to promote competition and improved performance. The selection of collection agencies and the timing of the referral of an account to a collection agency vary among hospitals. Generally, we do not write off accounts prior to utilizing the services of a collection agency. Once collection efforts have proven unsuccessful, an account is written off from our patient accounting system against the allowance for doubtful accounts. We determine the adequacy of the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the adequacy of the allowance. We monitor our revenue trends by payor classification on a quarter-by-quarter basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, accounts receivable, co-payment receivables and historic payment patterns. In addition, we analyze other factors such as day s revenue in accounts receivable and we review admissions and charges by physicians, primarily focusing on recently recruited	

physicians.

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

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

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Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Revenue recognition / Net Patient		
Service Revenues		
For our Healthcare Facilities Segment, we recognize revenues in the period in which services are provided. For our Specialty Pharmacy Segment, we recognize revenues in the period in which services are provided and at the time the customer takes possession of merchandise. Patient receivables primarily consist of amounts due from third-party payors and patients. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors, such as HMOs, PPOs and other private insurers, are determined pursuant to contracts or established government rates and are generally less than our established billing rates. Accordingly, our gross revenues and patient receivables are reduced to net amounts receivable pursuant to such contracts or government payment rates through an allowance for contractual discounts. Approximately 84.1%, 82.4% and 86.8% of our revenues during the years ended June 30, 2011, 2010 and 2009, respectively, relate to discounted charges. The sources of these revenues were as follows (as a percentage of total revenues):	Revenues are recorded at estimated amounts due from patients, third-party payors, institutions, pharmacies, and others for healthcare and pharmacy services and goods provided net of contractual discounts pursuant to contract or government payment rates. Estimates for contractual allowances are calculated using computerized and manual processes depending on the type of payor involved. In certain hospitals, the contractual allowances are calculated by a computerized system based on payment terms for each payor. In other hospitals, the contractual allowances are estimated manually using historical collections for each type of payor. For all hospitals, certain manual estimates are used in calculating contractual allowances based on historical collections from payors that are not significant or have not entered into a contract with us. All contractual adjustments regardless of type of payor or method of calculation are reviewed and compared to actual experience on a periodic basis.	
Medicare 40.9%; Medicaid 12.6%; and Commercial insurance 30.6%.	Accounts receivable primarily consist of amounts due from third party payors, institutions, pharmacies, and patients. Amounts we receive for the treatment of patients covered by HMOs, PPOs and other private insurers are generally less than our established billing rates. We include contractual allowances as a reduction to revenues in our financial statements based on payor specific identification and payor specific factors for rate increases and denials.	

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Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item	Assumption / Approach Used	Sensitivity Analysis
(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)
Revenue recognition / Net Patient Service Revenues (continued)		
	Governmental payors	**Governmental payors**
	The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under this prospective reimbursement system, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates. Discounts for retrospectively cost-based revenues, which were more prevalent in periods before 2000, are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under all programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely.	Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates of contractual discounts we record could change by material amounts. Adjustments related to final settlements for revenues retrospectively increased our revenues by the following amounts: 2011 $709; 2010 $1,201; and 2009 $394.
	Commercial Insurance	**Commercial Insurance**
	For most managed care plans, contractual allowances estimated at the time of service are adjusted to actual contractual allowances as cash is received and claims are reconciled. We evaluate the following criteria in developing the estimated contractual allowance percentages: historical contractual allowance trends based on actual claims paid by managed care payors; review of contractual allowance information reflecting current contract terms; consideration and analysis of changes in payor mix reimbursement levels; and other issues that may impact contractual allowances.	If our overall estimated contractual discount percentage on all of our commercial revenues during 2011 were changed by 1%, our 2011 after-tax income from continuing operations would change by approximately $231. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts would lower our

earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

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Balance Sheet or Income Statement Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Goodwill, other intangible assets and accounting for business combinations		
Goodwill represents the excess of the purchase price over the fair value of the net assets (including separately identified intangible assets) of acquired companies. The Company has two reportable business segment with goodwill. Our goodwill by business segment included in our consolidated balance sheets as of June 30 for the following years was as follows: **2011** **2010** Healthcare Facilities $ 931 $ 931 Pharmacy 461 6,509 $ 1,392 $ 7,440 The goodwill resulted from the 2004 acquisition of Healthmont, Inc. and the 2008 acquisition of Carmichael.	In accordance with FASB Accounting Standards Codification 350-10, Intangibles Goodwill and Other, (ASC 350-10) goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. For purposes of these analyses, our estimate of fair value is based on the income approach, which estimates the fair value based on our future discounted cash flows. Our estimate of future discounted cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. If we determine the carrying value of goodwill or other intangible assets to be impaired, then we reduce the carrying value.	As part of the fiscal 2011 goodwill and intangibles impairment analysis, the Company recognized that there has been significant declines in net revenue during FY 2011 for the Specialty Pharmacy Segment. The analysis resulted in a $6,048 goodwill impairment charge for fiscal 2011. Additionally, the Company recognized a $3,400 impairment charge to trade name and a $3,899 impairment charge to customer relationships for the fiscal year ended June 30, 2011.
The Company s intangible assets relate to Certificates of Need (CON), non-competition agreements, trade name, customer relationships and Medicare licenses. CON, Non-competition agreements, customer relationships, and Medicare licenses are amortized over the terms of the agreements. The trade name has been determined to have an indefinite life and, accordingly, is not amortized. Our other intangible assets by business segment included in our consolidated balance sheets as of June 30 for the following years was as follows: **2011** **2010** Healthcare Facilities Certificates of Need $ 80 $ 80 Noncompetition agreements 83 83 163 163 Accumulated amortization (91) (61) $ 72 $ 102 Pharmacy Trade name $ 2,000 $ 5,400	The purchase price of acquisitions is allocated to the assets acquired and liabilities assumed based upon their respective fair values and are subject to change during the twelve month period subsequent to the acquisition date. We engage independent third-party valuation firms to assist us in determining the fair values of assets acquired and liabilities assumed at the time of acquisition. Such valuations require us to make significant estimates and assumptions, including projections of future events and operating performance. Fair value estimates are derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows. Our estimate of future cash flows is based on assumptions and projections we believe to be currently	

Customer relationships	1,089	6,400	reasonable and supportable. Our
Medicare License	769	769	assumptions take into account revenue and expense growth rates, patient
	3,858	12,569	volumes, changes in payor mix, and
Accumulated amortization	(453)	(1,280)	changes in legislation and other payor payment patterns.
	$ 3,405	$ 11,289	
Total	$ 3,477	$ 11,391	

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Balance Sheet or Income Statement

Caption/Nature of Critical Estimate Item	Assumption / Approach Used	Sensitivity Analysis
(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)	(dollar amounts in thousands, except per share)
Professional and general liability claims		
We are subject to potential medical malpractice lawsuits and other claims as part of providing healthcare services. To mitigate a portion of this risk, we have maintained insurance for individual malpractice claims exceeding a self-insured retention amount. For the periods March 1, 2008 to February 28, 2009, March 1, 2009 to February 2010, March 1, 2010 to February 28, 2011 and March 1, 2011 to February 28, 2012 our self-insured retention level was $1,000 on individual malpractice claims.	The reserve for professional and general liability claims is based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors and other actuarial assumptions in the determination of reserve estimates.	Actuarial calculations include a large number of variables that may significantly impact the estimate of ultimate losses recorded during a reporting period. In determining loss estimates, professional judgment is used by each actuary by selecting factors that are considered appropriate by the actuary for our specific circumstances. Changes in assumptions used by our independent actuary with respect to demographics and geography, industry trends, development patterns and judgmental selection of other factors may impact our recorded reserve levels and our results of operations.
Each year, we obtain quotes from various malpractice insurers with respect to the cost of obtaining medical malpractice insurance coverage. We compare these quotes to our most recent actuarially determined estimates of losses at various self-insured retention levels. Accordingly, changes in insurance costs affect the self-insurance retention level we choose each year. As insurance costs increase, we may accept a higher level of risk in self-insured retention levels.	The reserve for professional and general liability claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances.	Changes in our initial estimates of professional and general liability claims are non-cash charges and accordingly, there would be no material impact currently on our liquidity or capital resources.
The reserve for professional and general liability claims included in our consolidated balance sheets as of June 30 was as follows: 2011 $4,143; and 2010 $3,343.	We revise our reserve estimation process by obtaining independent actuarial calculations quarterly. Our estimated reserve for professional and general liability claims will be significantly affected if current and future claims differ from historical trends. While we monitor reported claims closely and consider potential outcomes as estimated by our independent actuaries when determining our professional and general liability reserves, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicates the estimation process. In addition, certain states, including Georgia, have passed varying forms of tort reform which attempt to limit the number and types of claims and the amount of some medical malpractice awards. If enacted limitations remain in place or if similar laws are passed in the states where our hospitals are located, our loss estimates could decrease. Conversely, liberalization of the number and type of claims and damage awards permitted under any such law applicable to our operations could cause our loss estimates to increase.	
The total expense for professional and general liability coverage, included in our consolidated results of operations, was as follows: 2011 $ 1,968;		

2010 $ 1,495; and

2009 $1,962.

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Balance Sheet or Income Statement		
Caption/Nature of Critical Estimate Item	**Assumption / Approach Used**	**Sensitivity Analysis**
(dollar amounts in thousands, except per share)	**(dollar amounts in thousands, except per share)**	**(dollar amounts in thousands, except per share)**
Accounting for income taxes		
Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our income statement. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our net deferred tax asset balance (net of valuation allowance) in our consolidated balance sheets as of June 30 for the following years was as follows: 2011 $11,632; and 2010 $4,405.	The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in the first step of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities.	Our deferred tax assets are $13,710 and our deferred tax liabilities are $0 at June 30, 2011, excluding the impact of valuation allowances. The Company believes that the likelihood of our not realizing the federal tax benefit of our net deferred tax assets is remote. The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable loss for 2011, we would incur approximately $1,292 of additional tax benefit for 2011 plus applicable penalties and interest.
Our valuation allowances for deferred tax assets in our consolidated balance sheets as of June 30 for the following years were as follows: 2011 $2,078; and 2010 $1,350.	In assessing tax contingencies, we identify tax issues that we believe may be challenged upon examination by the taxing authorities. We also assess the likelihood of sustaining tax benefits associated with tax planning strategies and reduce tax benefits based on management s judgment regarding such likelihood. We compute the tax on each contingency. We then determine the amount of loss, or reduction in tax benefits based upon the foregoing and reflect such amount as a component of the provision for income taxes in the reporting period.	
In addition, significant judgment is required in determining and assessing the impact of certain tax-related contingencies. We establish accruals when, despite our belief that our tax return positions are fully supportable, it is probable that we have incurred a loss related to tax contingencies and the loss or range of loss can be reasonably estimated.	During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is	

	reflected as a reduction of the provision for income taxes in the current period.
We adjust the accruals related to tax contingencies as part of our provision for income taxes in our results of operations based upon changing facts and circumstances, such as the progress of a tax audit, development of industry related examination issues, as well as legislative, regulatory or judicial developments. A number of years may elapse before a particular matter, for which we have established an accrual, is audited and resolved.	

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Financial Summary

The results of continuing operations shown in the historical summary below are for our two business segments, Healthcare Facilities and Specialty Pharmacy.

	Years Ended June 30,		
	2011	2010	2009
Net Revenues Healthcare Facilities	$ 114,460	$ 123,360	$ 116,831
Net Revenues Specialty Pharmacy	39,920	42,962	46,130
Total Net Revenues	154,380	166,322	162,961
Costs and expenses	(157,630)	(165,005)	(157,686)
Impairment of goodwill and intangible assets	(13,347)		
Impairment of construction in progress		(1,202)	(433)
Gain on Sale of Home Health businesses		2,342	
Operating Profit	(16,597)	2,457	4,842
Interest Expense	(7,433)	(3,471)	(3,765)
Interest Income	5	14	50
Gains of sale of assets			180
Earnings (loss) from continuing operations before income taxes	$ (24,025)	$ (1,000)	$ 1,307
Healthcare Facilities Segment:			
Admissions	5,226	5,814	6,393
Equivalent Admissions	16,118	17,511	17,477
Surgeries	2,400	3,110	2,926
Revenue per Equivalent Admission	$ 7,092	$ 7,045	$ 6,685

Equivalent admissions Equivalent admissions is 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 to result in a general approximation of combined inpatient and outpatient volume (equivalent admissions).

Results of Operations

Our net revenues are from our two business segments, Healthcare Facilities and Specialty Pharmacy.

Healthcare Facilities Segment

Net revenue for the year ended June 30, 2011 were $114,460 with a total of 16,118 equivalent admissions and revenues per equivalent admission of $7,092 compared to net revenues of $123,260, a total of 17,511 equivalent admissions and revenues per equivalent admission of $7,045 for the year ended June 30, 2010.

The 7.2% decrease in net revenues for the year ended June 30, 2011 was due primarily to decreased Medicare, self-pay, and commercial and other revenues offset by increases in Medicaid revenues Medicaid net revenues increased less than 1% from the prior year. Net revenues for the fiscal year ended June 30, 2011 included revenues of $709 for the settlements and filings of prior year Medicare and Medicaid cost reports

compared to net revenue of $1,201 for the fiscal year ended June 30, 2010. Net revenue for the fiscal year ended June 30, 2011 and 2010, included net revenues of $3,461 and $4,803 respectively, from state indigent care programs. Net outpatient service revenues decreased $8,764, a 14.3% decrease from last year to $52,712, and decreased to 46.1% of net revenues from 49.8% last year.

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Net revenues for the year ended June 30, 2010 were $123,360 with a total of 17,511 equivalent admissions and revenues per equivalent admission of $7,045 compared to net revenues of $116,831, a total of 17,477 equivalent admissions and revenues per equivalent admission of $6,685 for the year ended June 30, 2009. The 5.6% increase in net revenues for the year ended June 30, 2010 was due primarily to increased Medicare, self pay and commercial and other revenues offset by decreases and Medicaid revenues, a 5.7% increase in net revenues per equivalent admission and increased revenue from settlements and filings of prior year Medicare and Medicaid cost reports. Net revenues for the fiscal year ended June 30, 2010 included revenues of $1,201 for the settlements and filings of prior year Medicare and Medicaid cost reports compared to net revenue of $394 for the fiscal year ended June 30, 2009. Self-pay revenues increased due to fewer patients having insurance and increased deductibles and co-insurance for insured patients. Self-pay revenues increased 41.5% in the fiscal year ended June 30, 2010 and commercial revenues increased 2.2%. Net outpatient service revenues increased $3,866, a 6.7% increase from the prior year to $61,476, and increased to 49.8% of net revenues from 49.3% the prior year.

The recruitment of new doctors and spending for capital improvements have contributed to the increase in Healthcare Facilities net revenues in the years ended June 30, 2011, 2010 and 2009, respectively. We experienced a net loss of five doctors during the fiscal year ended June 30, 2011, added two net new doctors during the fiscal year ended June 30, 2010, and added two net new doctors during the fiscal year ended June 30, 2009. During the fiscal year ended June 30, 2011, SunLink expensed $278 on physician guarantees and recruiting expenses compared to $458 last year. We also have expended approximately $5,957 for capital expenditures to upgrade services and facilities since July 1, 2008. We believe the upgraded services and facilities contributed to the increase in net revenue per equivalent admission for the years ended June 30, 2011 and 2010, respectively, compared to the prior years. We continue to seek increased patient volume by attracting additional physicians to our hospitals, upgrading the services offered by our hospitals on an as needed basis and improving our hospitals physical facilities based on the availability of capital resources and our assessment of expected return on capital.

The following table sets forth the percentage of net patient revenues from major payors for the Healthcare Facilities Segment for the periods indicated:

	Fiscal Years Ended June 30,		
	2011	2010	2009
Source			
Medicare	40.9%	38.9%	39.5%
Medicaid	12.6%	11.6%	14.5%
Self pay	15.9%	17.6%	13.2%
Commercial Insurance & Other	30.6%	31.9%	32.8%
	100.0%	100.0%	100.0%

The decrease in net revenues for the year ended June 30, 2011 was due to decreased Medicare self-pay and commercial insurance and other revenues only slightly offset by a less than 1% increase in Medicaid. Medicare net revenues decreased $1,266, a 2.6% decrease from last year. Medicaid net revenues increased $93, a 0.6% increase from last year, and increased 1.0% as a percentage of total net revenues in fiscal year 2011 compared to fiscal year 2010. Commercial insurance and other decreased $4,307, an 11.0% decrease from last year and decreased to 30.6% of net revenues from 31.9% last year. Self-pay revenues decreased $3,569, a 16.4% decrease from last year and decreased to 15.9% of net revenues from 17.6% last year. The changes were due primarily to increased patients without medical insurance and increased deductibles and co-insurance required for insured patients.

Specialty Pharmacy Segment

Net revenues were $39,920, $42,962 and $46,130 for the fiscal years ended June 30, 2011, 2010 and 2009, respectively. Fiscal 2011 net revenues decreased $3,042, or 7.1%, as compared to fiscal 2010 net revenues primarily as a result of the loss of certain direct contracts for institutional pharmacy products and services of $2,731 and a

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decrease in durable medical equipment sales of $532. The decrease resulted from a decrease in pharmacy revenue, primarily due to lower sales of pharmacy products due to the loss of supply arrangements with two long-term care facilities compared to the prior year. Fiscal 2010 net revenues decreased $3,168, or 6.9%, as compared to the fiscal prior year. The decrease resulted from decreases in pharmacy net revenues, primarily one infusion therapy drug prescribed for premature babies at high risk for lung disease, and durable medical equipment sales. During Fiscal 2010, Louisiana Medicaid, the major payor for this infusion therapy drug, reduced the utilization of the drug, thereby reducing net revenues of the Specialty Pharmacy Segment by $4,315 for Fiscal 2010.

Healthcare Facilities Segment Cost and Expenses

Costs and expenses for our Healthcare Facilities, including depreciation and amortization, were $111,028, $117,762, and $108,403, for the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

	Cost and Expenses as a % of Net Revenue Years Ended June 30,		
	2011	2010	2009
Salaries, wages and benefits	46.9%	44.8%	45.6%
Provision for bad debts	13.6%	15.3%	13.4%
Supplies	9.5%	9.8%	9.5%
Purchased services	7.5%	6.8%	7.0%
Other operating expenses	14.2%	12.6%	11.3%
Rent and lease expense	2.2%	1.9%	1.9%
Depreciation and amortization expense	3.2%	3.3%	3.7%

Salaries, wages and benefits expense as a percentage of total net revenues increased in the year ended June 30, 2011 compared to the prior year due to lower net patient revenues in the current year. Salaries, wages and benefits expense decreased by $1,662, or 3.0% in year ended June 30, 2011 due to the lower staffing levels needed for the lower patient volume.

Provision for bad debts decreased as a percentage of net revenue in the year ended June 30, 2011 compared to the prior year due lower self-pay net revenues. Self-pay revenues decreased $3,569 or 16.4% in the current fiscal year. Provision for bad debts increased as a percentage of net revenue in the year ended June 30, 2010 compared to the prior year due to fewer people being eligible for Medicaid due to more stringent Medicaid requirements, increased coinsurance and deductible amounts that insured persons have to pay, overall decreased collections as a percentage of revenues and higher self-pay net revenues. Self-pay revenues increased $6,385 or 41.5% in the fiscal year 2010.

Other operating expenses increased as a percentage of net revenues in the year ended June 30, 2011 compared to the prior year due to increased insurance expense. The increase in other operating expenses was also due to recording a new healthcare provider tax for our three Georgia healthcare facilities as other expense. Provider tax recorded in other expense was $2,659 and $2,162 for the fiscal years ended June 30, 2011 and 2010, respectively. States in which the Company operates hospitals have imposed and increased their provider tax in the last two years.

Other operating expenses increased as a percentage of net revenues in the year ended June 30, 2010 compared to the prior year due to recording state provider tax as other expense in 2010. For the fiscal year ended June 30, 2010, the Missouri and Mississippi hospitals paid state provider tax totaling $2,162 which is included in other operating expenses as opposed to Medicaid contractual allowances where they had been classified in prior years. The reclassification was done to more properly show these taxes as expenses for providing patient care.

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Depreciation and amortization expense was $3,675, $4,040, and $4,266 for the years ended June 30, 2011, 2010 and, 2009, respectively. The decrease in fiscal year 2011 depreciation and amortization expense compared to fiscal year 2010 resulted from assets being fully depreciated in the current year as compared to prior years.

Specialty Pharmacy Segment Cost and Expenses

Cost and expenses for our Specialty Pharmacy Segment, including depreciation and amortization, was $41,036, $43,383 and $44,334 for the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

	Cost and Expenses as a % of Net Revenue Years Ended June 30,		
	2011	2010	2009
Cost of goods sold	69.7%	68.8%	67.1%
Salaries, wages and benefits	17.4%	16.3%	14.6%
Provision for bad debts	3.2%	3.5%	5.1%
Supplies	0.5%	0.6%	0.4%
Purchased services	3.7%	4.1%	2.4%
Other operating expenses	3.6%	3.2%	2.8%
Rent and lease expense	0.8%	0.6%	0.6%
Depreciation and amortization expense	3.9%	3.8%	3.3%

Cost of goods sold as a percent of net revenues increased in the fiscal year ended June 30, 2011 as compared to the prior year due to changes in sales product mix, offset slightly by favorable pricing negotiations and discounts earned with certain suppliers. Generally, Medicare and Medicaid reimbursement rates decreased in fiscal 2011 as compared to the prior year. Salaries, wages and benefits increased as a percent of net revenues in fiscal 2011 as compared to the prior year primarily due to increased staffing in the accounting and business office areas needed for implementing new software systems and implementing and improving system controls and procedures as a result of changes in the operations effected by management. Purchased services decreased as a percent of net revenues in fiscal 2011 as compared to the prior year due to reductions in the use of accounting consulting services and legal costs as compared to the prior year. The provision for bad debts as a percent of net revenues decreased during fiscal 2011 as the improved controls and procedures in the business office increased collections of accounts receivable resulting in lower uncollectible account write-offs.

Corporate Overhead Costs and Expenses

Cost and expenses for Corporate Overhead including depreciation and amortization, was $5,566, $5,065 and $5,382 for the fiscal years ended June 30, 2011, 2010 and 2009, respectively. The increase in the fiscal year ended June 30, 2011 from the prior year was due to $483 of severance expense paid for four corporate employees. The decrease in the fiscal year ended June 30, 2010 from the prior year was due to decreased legal and audit expenses, decreased directors fees and stock option compensation expense, partially offset by increased depreciation expense.

Impairment of Goodwill and Intangible Assets

As part of the fiscal 2011 goodwill and intangibles impairment analysis, the Company recognized that there has been a continuing decline in the revenues and operating profit from the Specialty Pharmacy Segment. The analysis resulted in a $6,048 goodwill impairment charge for fiscal 2011 for goodwill resulting from the April 2008 acquisition of Carmichael. Additionally, the Company recognized a $3,400 impairment charge to trade name and a

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$3,899 impairment charge to customer relationships acquired in the April 2008 acquisition of Carmichael for the fiscal year ended June 30, 2011. Declines in pharmacy products and services revenues during the fiscal year ended June 30, 2011 resulted from the loss of direct sales contracts for institutional pharmacy products and lower retail demand. Eight long-term care facilities converted their supply contracts to pharmacy management contracts in the fourth quarter of fiscal 2011 and these pharmacy management contracts yield lower operating profit margins for Carmichael. The continuing depressed local economy of Carmichael s service area has resulted in lower sales for retail pharmacy and durable medical equipment products and we have projected these lower sales volumes will continue.

The following table summarizes goodwill and intangible asset impairment charges for the fiscal year ended June 30, 2011:

	June 30, 2011
Specialty Pharmacy Segment	
Goodwill	$ 6,048
Intangible assets	
Trade Name	3,400
Customer Relationships	3,899
Total	$ 13,347

Impairment of Construction in Progress

In August 2007, the Company received final approval of a Certificate of Need (CON) application with the State of Georgia to build a replacement hospital in Ellijay, Georgia and incurred CON application costs, land use, architecture and building consultants costs which were capitalized as construction in progress. SunLink exercised its option to purchase land in Ellijay to build the replacement hospital; however, the owner failed to close. We are currently in litigation with the owner and are pursuing a claim for damages against the owner based upon the owner s failure to close the sale as agreed. The outcome of the litigation is uncertain. During the year ended June 30, 2009, SunLink expensed $433 of costs which had been capitalized relating to the land. During the fiscal year ended June 30, 2010, an additional $1,202 that had been incurred and capitalized prior to June 30, 2009 was expensed. These capitalized costs relate to CON, architecture and building consultants costs for the projected building site. The project to build a replacement hospital in Ellijay, Georgia at a site other than the existing hospital location is now considered remote due to the difficulty in obtaining a suitable building site. The Company is considering alternatives for upgrading the facilities at the existing hospital site.

Operating Profit

Operating loss was $16,597 for the year ended June 30, 2011 and operating income was $2,457 and $4,842 for the years ended June 30, 2010 and, 2009, respectively. The operating loss in the year ended June 30, 2011 compared to the prior year was due to an impairment charge of $6,508 against goodwill and $7,299 against intangible assets associated with the Specialty Pharmacy Segment and lower operating profit due to the decrease in net revenues for the Healthcare Facilities and Specialty Pharmacy Segments. The decrease in operating profit in the year ended June 30, 2010 compared to the prior year was due to a decrease in net revenues for the Specialty Pharmacy Segment, an increase in cost and expenses, especially provision for bad debts and other operating expenses and an increase in the impairment of construction in process offset by the gain on sale of three home health businesses included in operating profit.

Interest expense was $7,433, $3,471, and $3,765 for the years ended June 30, 2011, 2010 and, 2009, respectively. The increase in fiscal years 2011 interest expense resulted from $1,485 in waiver fees paid as required under the Credit Facility Waiver, $990 of increased deferred financing cost amortization this year resulting from the change in the termination date of the Credit Facility from April 2017 to September 2011 and increased rates charged as a result of the Credit Facility Waiver. As of June 30, 2011 and 2010, our outstanding balance on our credit agreement was $31,853 and $33,386, respectively. The outstanding balance on our revolving line of credit was $5,300 and $0 as of June 30, 2011 and 2010, respectively.

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We recorded income tax benefit of $8,609 ($8,188 federal tax benefit and $421 state tax benefit) for the year ended June 30, 2011 compared to income tax benefit of $578 ($420 federal tax benefit and $158 state tax benefit) for the year ended June 30, 2010 and income tax expense of $696 ($682 federal and $14 state tax expense) for the year ended June 30, 2009. The $8,609 tax benefit for the year ended June 30, 2011 included a $7,775 deferred tax benefit. The deferred tax benefit resulted primarily from impairment of goodwill and intangible assets of $13,347 pre-tax of the Specialty Pharmacy Segment and the receipt of Medicare EHR incentive reimbursement payments of $8,521 which were included in taxable income in the current year but which were deferred from inclusion in pre-tax income this year. The $578 federal tax benefit for the year ended June 30, 2010 included a $1,495 deferred tax benefit. The $696 federal tax expense for the year ended June 30, 2009 included a $1,428 deferred tax benefit. We had an estimated net operating loss carry-forward for federal income tax purposes of approximately $6,150 at June 30, 2011. Use of this net operating loss carry-forward is subject to the limitation provisions of Internal Revenue Code Section 382. As a result, not all of the net operating loss carry-forward is available to offset federal taxable income in the current year. We have provided a valuation allowance for $2,078 of our $13,710 gross deferred tax asset (the majority of which is the net operating loss carry-forward for federal income tax purposes). Based upon management s assessment that it was more likely than not that a portion of its deferred tax asset (primarily its net operating losses subject to limitation) would not be recovered, the Company established a valuation allowance for the portion of the domestic tax asset which may not be utilized.

Loss from continuing operations was $15,416 ($1.90 loss per fully diluted share) for the year ended June 30, 2011 compared to loss from continuing operations of $422 ($0.05 loss per fully diluted share) for the year ended June 30, 2010 and earnings from continuing operations of $611 ($0.08 per fully diluted share) for the year ended June 30, 2009. Loss from continuing operations in fiscal 2011 resulted from an impairment charge of $6,048 against goodwill and $7,299 against intangible assets associated with the Specialty Pharmacy Segment, decreased net revenues for the Specialty Pharmacy Segment and an increase in interest expense. Loss from continuing operations in fiscal 2010 resulted from an increase in cost and expenses, especially provision for bad debts, other operating expenses and the increased impairment of construction in progress partially offset by the gain on sale of three home health businesses included in operating profit. Earnings from continuing operations in fiscal 2009 decreased from fiscal 2008 due to increased operating profit which resulted from settlements and filings of prior year Medicare and Medicaid cost reports and the reversal of the lease guarantee obligation recorded during the Healthmont acquisition.

Loss from discontinued operations of $687 for the year ended June 30, 2011 primarily resulted from $524 of loss after tax on the operations of the held for sale Memorial of Adel hospital (Adel), $228 of earnings after tax expense attributable to our former Mountainside operations, due to the settlement of a lawsuit, $55 of losses after tax benefit resulting from domestic pension items and $336 of losses after tax expense from our formerly owned Chilton Medical Center resulting from $724 of pre-tax loss from operations offset by $438 related to the pre-tax gain on the sale of the operations of Chilton Medical Center. Earnings from discontinued operations of $524 for the year ended June 30, 2010 primarily resulted from $1,493 of after tax expense attributable to our former Mountainside operations, $436 of loss after tax on the operations of Adel, $400 of losses after tax benefit attributable to our former KRUG UK operations, primarily due to legal expenses, $61 of losses after tax benefit resulting from domestic pension items and $72 of losses after tax benefit from operations of our formerly owned Chilton Medical Center. Earnings from discontinued operations of $301 for the year ended June 30, 2009 resulted from $77 of losses after tax benefit from Mountainside, $194 of earnings after tax on the operations of Adel, $135 of losses after tax benefit from KRUG UK, primarily due to legal expenses, $33 of losses after tax benefit resulting from domestic pension items offset by $262 of earnings after tax expense from operations of our formerly owned Chilton Medical Center.

Net loss for the year ended June 30, 2011 was $16,103 ($1.99 loss per fully diluted share) compared to net earnings of $102 ($0.01 per fully diluted share) for the year ended June 30, 2010 and $912 ($0.11 per fully diluted share) for the year ended June 30, 2009.

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Earnings before income taxes, interest, depreciation and amortization

Earnings before income taxes, interest, depreciation and amortization (EBITDA) represent the sum of income before income taxes, interest, depreciation and amortization. We understand that certain industry analysts and investors generally consider EBITDA to be one measure of the liquidity of a company, and it is presented to assist analysts and investors in analyzing the ability of a company to generate cash, service debt and meet capital requirements. We believe increased EBITDA is an indicator of improved ability to service existing debt and to satisfy capital requirements. EBITDA, however, is not a measure of financial performance under accounting principles generally accepted in the United States of America and should not be considered an alternative to net income as a measure of operating performance or to cash liquidity. Because EBITDA is not a measure determined in accordance with accounting principles generally accepted in the United States of America and is thus susceptible to varying calculations, EBITDA, as presented, may not be comparable to other similarly titled measures of other corporations. Where we adjust EBITDA for non-cash charges we refer to such measurement as Adjusted EBITDA , which we report on a company wide basis. Non-cash adjustments in Adjusted EBITDA are not intended to be identified or characterized in any respect as non-recurring, infrequent or unusual, if we believe such charge is reasonably likely to recur within two years, or if there was a similar charge (or gain) within the prior two years. Where we report Adjusted EBITDA, we typically also report Hospital Facilities Segment Adjusted EBITDA and Specialty Pharmacy Segment Adjusted EBITDA which is the EBITDA for the applicable segments without any allocation of corporate overhead, which we report as a separate line item, and without any allocation of the non-cash adjustments, which we also report as a separate line item in Adjusted EBITDA. Net cash provided by operations for the years ended June 30, 2011, 2010 and 2009, respectively, is shown below.

	Years ended June 30,		
	2011	2010	2009
Healthcare Facilities Adjusted EBITDA	$ 7,037	$ 12,435	$ 13,144
Specialty Pharmacy Adjusted EBITDA	446	1,215	3,394
Corporate overhead costs	(5,036)	(5,069)	(5,017)
Taxes and net interest expense	1,298	(2,814)	(4,668)
Other non-cash expenses and net changes in operating assets and liabilities	1,034	(1,839)	(2,423)
Net cash provided by operations	$ 4,779	$ 3,928	$ 4,430

Liquidity and Capital Resources

We generated $4,779 of cash from operations during the year ended June 30, 2011 compared to $3,928 from operations during the prior year. Cash was generated from receipt of $8,521 in EHR incentive reimbursements in May 2011.

We generated $3,928 of cash from operations during the year ended June 30, 2010 compared to $4,430 from operations during the comparable period of the prior year. Cash was generated from net earnings, non-cash expenses of impairment of construction in process and depreciation, and cash provided by discontinued operations partially offset by decreased accounts payable and accrued expenses.

SunLink expended $2,844, $2,502 and $1,484 for capital expenditures at our Healthcare Facilities and Specialty Pharmacy Segments during the years ended June 30, 2011, 2010 and 2009, respectively. We believe an attractive and up-to-date physical facilities assist in recruiting quality staff and physicians, as well as attracting patients, and the capital expenditures in fiscal year 2011 related primarily to information technology capital for the Healthcare Facilities and Specialty Pharmacy Segments.

SunLink s Credit Facility at June 30, 2011 is comprised of a revolving line of credit of up to $9,000 with an interest rate at LIBOR plus 10.5% (13.25% at June 30, 2011) (the Revolving Loan) of which $5,300 was outstanding and a Term Loan with an outstanding balance of $29,086 with an interest rate at LIBOR plus 12.07%

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(14.82% at June 30, 2011) (the Term Loan). A modification to the Credit Facility was entered into on July 28, 2011 (July 2011 Modification) at which time SunLink made an $8,000 prepayment of the Term Loan and paid a modification fee of $131. The source of the repayment was $2,500 of proceeds from a private placement of SunLink common shares primarily to directors and affiliates and $5,500 of operating funds. Under the July 2011 Modification, the interest rate under the Revolving Loan was adjusted to LIBOR plus 8.875%, or 11.625% and the interest rate under the Term Loan was adjusted to LIBOR plus 10.82%, or 13.57%. The termination date of the Credit Facility was changed to January 1, 2013. The maximum availability of the Revolving Loan is $9,000 and is keyed to the calculated net collectible value of eligible accounts receivable. The financial covenants were also adjusted in the July 2011 Modification. The Credit Facility is secured by a first priority security interest in substantially all real and personal property of the Company and its consolidated domestic subsidiaries, including a pledge of all of the equity interests in such subsidiaries.

The Credit Facility contains various terms and conditions, including operational and financial restrictions and limitations, and affirmative and negative covenants. The covenants include financial covenants measured on a quarterly basis which require SunLink to comply with maximum leverage and minimum fixed charge ratios, maximum capital expenditure amounts, collateral value to loan amount and liquidity and cash flow measures, all as defined in the Credit Facility. Although SunLink was not in compliance with certain of the financial covenants contained in the Credit Facility at June 30, 2011, the Credit Facility was subsequently amended by the July 2011 Modification to change the affected covenants so as to bring us into compliance. At June 30, 2011, SunLink was in compliance with the financial covenants of the Credit Facility as modified in the July 28, 2011 modification. We believe that the Company should be able to continue in compliance with the revised levels of financial covenants and terms in the Credit Facility during the fiscal year ending June 30, 2012, but there is no assurance that the Company will remain in compliance with all of the terms and conditions of the Credit Facility in subsequent fiscal quarters. The July 28, 2011 modification includes other conditions related to Term Loan reductions by September 30, 2011 and December 31, 2011 which if not met may increase the interest rate for both the Term Loan and the Revolving Loan by an additional 0.5% over the prescribed interest rate for the remainder of the agreement. If the Term Loan reduction covenants are met, the interest rate for both the Term Loan and the Revolving Loan may decrease by an additional 1.25% over the prescribed interest rate for the remainder of the agreement. If we fail to remain in compliance with the Credit Facility, we would cease to have a right to draw on the revolving line of credit facility and the lenders would, among other things, be entitled to call a default and demand repayment of the indebtedness outstanding. If SunLink or its applicable subsidiaries experience a material adverse change in their business, assets, financial condition, management or operations, or if the value of the collateral securing the Credit Facility decreases, we may be unable to draw on the credit facility.

We believe we have adequate financing and liquidity to support our current level of operations through the next twelve months under the Credit Facility if we remain in compliance with all the current terms as modified. Failure to remain in compliance with all the terms of the Credit Facility could have adverse material effects on the Company. Our primary sources of liquidity are cash generated from continuing operations and availability under Revolving Loan component of the Credit Facility. The total availability of credit under the Revolving Loan is keyed to the level of SunLink s calculated net collectible value of eligible accounts receivable, which was $7,860 of which $5,300 was outstanding at June 30, 2011. The current remaining availability under the Revolving Loan could be adversely affected by, among other things, the risk, uncertainties and other factors listed at the beginning of Item 7, as well as lower earnings due to lower demand for our services by patients, changes in patient mix and changes in terms and levels of government and private reimbursement for services. Cash generated from operations could be adversely affected by, among other things, the risks, uncertainties and other factors listed at the beginning of Item 7, as well as lower patient demand for our services, higher operating costs (including, but not limited to, salaries, wages and benefits, provisions for bad debts, general liability and other insurance costs, cost of pharmaceutical drugs and other operating expenses) or by changes in terms and levels of government and private reimbursement for services, and the regulatory environment of the community hospital segment.

Contractual Obligations, Commitments and Contingencies

Contractual obligations related to long-term debt, non-cancelable operating leases and interest on outstanding debt from continuing operations at June 30, 2011 is shown in the following table. The interest on variable interest debt is calculated at the interest rate in effect at June 30, 2011.

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Payments due in:	Long-Term Debt	Subordinated Long-Term Debt	Operating Leases	Interest on Long-Term Debt	Interest on Subordinated Long-Term Debt
1 year	$ 1,814	$ 300	$ 2,573	$ 3,079	$ 188
2 years	27,409	300	1,134	1,343	164
3 years	32	300	668	1	140
4 years		1,597	514		64
5 years			370		
More than 5 years			700		
	$ 29,255	$ 2,497	$ 5,959	$ 4,423	$ 556

At June 30, 2011, SunLink had guarantee agreements with three physicians. A physician with whom a guarantee agreement is made generally agrees to maintain his or her practice within a hospital geographic area for a specific period (normally three years) or be liable to repay all or a portion of the guarantee received. The physician s liability for any guarantee repayment due to non-compliance with the provisions of a guarantee agreement generally is collateralized by the physician s patient accounts receivable and/or a promissory note from the physician. All potential payments payable under the three guarantees have been paid as of June 30, 2011. SunLink expensed $333, $596, and $750, for the fiscal years ended June 30, 2011, 2010 and 2009, respectively. There were no remaining non-cancelable commitments under guarantee agreements with physicians as of June 30, 2011.

At June 30, 2011, we had outstanding long-term debt of $29,255 of which $29,086 was incurred in connection with the Credit Facility and $169 was related to capital leases. At June 30, 2010, we had outstanding long-term debt of $30,887 of which $30,836 was incurred in connection with the Credit Facility and $51 was related to capital leases.

On December 7, 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.

In January 2008, the Mundys filed a motion to strike, motion to dismiss, answer, affirmative defenses, and a counterclaim against SHC-Ellijay. On March 3, 2009, SHC-Ellijay filed a First Amended and Restated Complaint for Damages, which effectively dropped the cause of action for specific performance of the Option Agreement. On May 7, 2009, Mr. Garrett and Ms. Mundy served a motion for summary judgment on all counts and causes of action stated in the First Amended Complaint. The court has postponed consideration of the defendants motion for summary judgment and SHC-Ellijay s response thereto until after a discovery dispute between the parties has been resolved.

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

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

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

Sarbanes-Oxley Section 404

This Annual Report on Form 10-K/A does not include an attestation report of our registered public accounting firm regarding internal controls over financial reporting. Management s report was not subject to attestation by our independent registered public accounting firm pursuant to the permanent exemption for non-accelerated filers from the internal control audit requirement of Section 404(b) of the Sarbanes-Oxley Act of 2002 (SOX) enacted under Section 989G of the Dodd-Frank Wall Street Reform and Consumer Protection Act.

Recent Accounting Pronouncements

In June 2009, the FASB issued SFAS No. 168, *The FASB Accounting Standards Codification and the Hierarchy of Generally Accepted Accounting Principles* (ASC 105, *Generally Accepted Accounting Principles*) ASC 105 . ASC 105 replaces SFAS No. 162, *The Hierarchy of Generally Accepted Accounting Principles*, and establishes the *FASB Accounting Standards Codification* (Codification) as the source of authoritative accounting principles recognized by the FASB to be applied by nongovernmental entities in the preparation of financial statements in conformity with GAAP. On the effective date of this Statement, the Codification superseded all then-existing non-SEC accounting and reporting standards. ASC 105 became effective for financial statements issued for interim and annual periods ending after September 15, 2009. The Codification is effective for the accompanying interim financial statements and the principal impact is limited to disclosures as all future references to authoritative literature will be referenced in accordance with the Codification.

In July 2011, the FASB issued ASU 2011-7, *Health Care Entities (Topic 954) Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* (ASU 2011-7). In accordance with ASU 2011-7, the Company will be required to present its provision for doubtful accounts related to patient service revenue as a deduction from revenue, similar to contractual discounts. Accordingly, the Company s revenues will be required to be reported net of both contractual discounts as well as its provision for doubtful accounts related to patient service revenues. Additionally, ASU 2011-7 will require the Company to make certain additional disclosures designed to help users understand how contractual discounts and bad debts affect recorded revenue in both interim and annual financial statements. ASU 2011-7 is required to be applied retrospectively and is effective for public companies for fiscal years beginning after December 15, 2011, and interim periods within those fiscal years. Early adoption is permitted. The adoption of ASU 2011-7 is not expected to impact the Company s financial position, results of operations or cash flows although it will change the presentation of the Company s revenues on its statements of operations as well as requiring additional disclosures.

In June 2011, the FASB issued ASU 2011-5, *Comprehensive Income (Topic 220) Presentation of Comprehensive Income* (ASU 2011-5). ASU 2011-5 eliminates the Company s currently elected option to present components of other comprehensive income as part of the statement of changes in stockholders equity. Instead, ASU 2011-5 requires that all non-owner changes in stockholders equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. ASU 2011-5 is required to be applied retrospectively and is effective for public companies for fiscal years beginning after December 15, 2011, and interim periods within those fiscal years. Early adoption is permitted. The Company anticipates applying the provisions of ASU 2011-5 for its fiscal year ending June 30, 2012. The adoption of ASU 2011-5 is not expected to impact the Company s financial position, results of operations or cash flows prospectively.

In September 2006, the FASB issued new accounting guidance related to fair value measurements and related disclosures. This new guidance defined fair value, established a framework for measuring fair value, and expanded disclosures about fair value measurements. We adopted this new guidance on July 1, 2008, as required for our financial assets and financial liabilities. However, the FASB deferred the effective date of this new guidance for one year as it related to fair value measurement requirements for nonfinancial assets and liabilities that are recognized or disclosed at fair value on a recurring basis. We adopted these remaining provisions on July 1, 2009. The adoption of this accounting guidance did not have a material impact on our consolidated financial statements.

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In December 2007, the FASB issued new accounting guidance related to the accounting for non controlling interests in consolidated financial statements. This guidance established accounting and reporting standards for the noncontrolling interest in a subsidiary and for the deconsolidation of a subsidiary. This guidance required that noncontrolling interests in subsidiaries be reported in the equity section of the controlling company s balance sheet. It also changed the manner in which the net income of the subsidiary is reported and disclosed in the controlling company s income statement. This guidance is effective for fiscal years beginning after December 15, 2008. We adopted this guidance on July 1, 2009 and reclassified minority interest to the equity section of the balance sheet. (See Note 12 Noncontrolling Interest)

Related Party Transactions

A director of the Company and the Company s secretary are members of two different law firms, each of which provides services to SunLink. We have paid an aggregate of $896, $585, and $1,154 to these law firms in the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

Inflation

During periods of inflation and labor shortages, employee wages increase and suppliers pass along rising costs to us in the form of higher prices for their supplies and services. We have not always been able to offset increases in operating costs by increasing prices for our services and products or by implementing cost control measures. We are unable to predict our ability to control future cost increases or offset future cost increases by passing along the increased cost to customers.

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Item 8. Financial Statements and Supplementary Data.

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Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

As required by Rule 13a-15 under the Securities Exchange Act of 1934 (the Exchange Act), as of the end of the period covered by this report, we originally carried out an evaluation of the effectiveness of the design and operation of our Company s disclosure controls and procedures. Under the direction of our principal executive officer and principal financial officer, we evaluated our disclosure controls and procedures and internal control over financial reporting and originally concluded that our disclosure controls and procedures were effective as of June 30, 2011.

Disclosure controls and procedures and other procedures are designed to ensure that information required to be disclosed in our reports or submitted under the Exchange Act, such as this Amendment No. 1 to our Annual Report on Form 10-K/A, is recorded, processed, summarized and reported within the time period specified in the SEC s rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed in our reports filed under the Exchange Act is accumulated and communicated to management, including our principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure.

Based on an evaluation of the effectiveness of disclosure controls and procedures performed in connection with the preparation of this Amendment No. 1 to our Annual Report on Form 10-K/A, our chief executive officer and chief financial officer concluded that, for the reasons set forth below under Management s Report on Internal Control Over Financial Reporting, our disclosure controls and procedures were not effective as of June 30, 2011. In addition, our chief executive officer and chief financial officer also have reevaluated the conclusions regarding our disclosure controls and procedures for other prior periods and have concluded that our disclosure controls and procedures were not effective as of: the quarterly period ended March 31, 2011, the quarterly period ended September 30, 2011 and the quarterly period ended December 31, 2011 for the same reason.

Management s Responsibility for Financial Statements

Our management is responsible for the integrity and objectivity of all information presented in this Annual Report on Form 10-K/A. The consolidated financial statements contained herein were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management s best estimates and judgments. Management believes the consolidated financial statements fairly reflect the form and substance of transactions and that the financial statements fairly represent the Company s financial position and results of operations.

The Audit Committee of the Board of Directors, which is composed solely of independent directors, meets regularly with the Company s independent registered public accounting firm and representatives of management to

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review accounting, financial reporting, internal control and audit matters, as well as the nature and extent of the audit effort. The Audit Committee is responsible for the engagement of the independent registered public accounting firm. The independent registered public accounting firm has free access to the Audit Committee.

Management s Report on Internal Control Over Financial Reporting

The Company s management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). The Company s management, including its principal executive officer and principal financial officer, conducted an evaluation of the effectiveness of its internal control over financial reporting based on the framework in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission. The scope of management s assessment of the effectiveness of internal control over financial reporting includes all of our businesses.

All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions.

In SunLink s annual report on Form 10-K filed on September 27, 2011, based on management s evaluation under the framework in Internal Control Integrated Framework, the Company s management originally concluded that the Company s internal control over financial reporting was effective as of June 30, 2011.

The Health Information Technology for Economic and Clinical Health Act, promulgated as part of the American Recovery and Reinvestment Act of 2009, provides for Medicare and Medicaid incentive payments beginning in calendar year 2011 for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record technology. Each of SunLink s five operating hospitals and its formerly owned Chilton Medical Center (Chilton) and its held-for-sale Memorial Hospital of Adel (Adel) registered for the program with CMS and, on April 18, 2011, all successfully attested compliance with Part I of the Medicare EHR incentive program for such first year. The Company has also successfully attested to the meaningful use requirements for Medicaid programs for its five operating hospitals as have Chilton and Adel. The Company has the right to receive 75% of EHR received by Chilton under a 2011 sale agreement. The Company has received approximately $7,731 in Medicare EHR incentive funds and approximately $2,169 in Medicaid EHR incentive funds to date, which includes Adel s funds. The Company also has received approximately $790 Medicare EHR incentive funds and approximately $188 Medicaid HER incentive funds to date from Chilton.

For Medicare and Medicaid EHR incentive payments prior to the beginning of the quarter ended December 31, 2011, SunLink followed what it considered the existing accounting guidance and utilized a grant accounting model to recognize these incentive payments. Under this accounting policy, EHR incentive payments were recognized as revenues when attestation that the EHR meaningful use criteria for the required period of time was demonstrated and were recognized ratably over the relevant cost report period to determine the amount of reimbursement. This accounting policy was specifically reviewed on several occasions in the past by the Company s management and the Audit Committee of the Company s Board of Directors. In addition, the Company s believed its practices were similar to those being used by other healthcare companies.

During the quarter ended December 31, 2011, SunLink became aware of what it understood to be the position of the staff (Staff) of the SEC regarding incentive reimbursement accounting for public companies. The Company gained such knowledge from its review of filings of other public companies and the issues analysis paper issued by the Healthcare Financial Management Association in December 2011. In light of what the Company understood were the Staff s views, the Company elected to apply such interpretation of accounting for the EHR incentive reimbursement to future transactions beginning with the quarter ended December 31, 2011. Accordingly, the Company changed its recognition policy to a gain contingency accounting model for incentive payments recognized after October 1, 2011 based upon the Company s understanding of the informal guidance provided by the SEC and certain other non-authoritative guidance. SunLink also reclassified the incentive payment income to a line item in the Costs and Expense category of the Consolidated Statement of Earnings and Loss and is reclassifying herein the amounts previously reported as revenue as a line item in the Costs and Expense category of the consolidated Statement of Earnings and Loss for previously reported periods presented in this and other applicable

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amended periodic reports. Under the gain contingency based model, EHR incentive payments are recognized when all contingencies relating to the incentive payment have been satisfied and compliance with the EHR meaningful use criteria have been attested to. For recognition of Medicaid EHR incentive payments, recognition of the payments will be at the time of attestation to EHR meaningful use criteria since Medicaid payments for the states in which the Company operates are based upon historical cost report information with no subsequent payment adjustment. However, for Medicare EHR incentive payments, recognition is being deferred until both the Medicare federal fiscal year during which EHR meaningful use was demonstrated ends and the cost report information utilized to determine the final amount of reimbursement is known.

On February 2, 2012, the Company received a letter from the Staff of the SEC with respect to the Staff s review of, and comments on, the Company s Form 10-K for the fiscal year ended June 30, 2011 (the Form 10-K) and the Company s Form 10-Q for the fiscal quarter ended September 30, 2011 (the Form 10-Q). Following correspondence and other communications with the Staff, on April 24, 2012, SunLink received correspondence from the Staff asserting the Staff s view that, among other things, the Company s prior accounting for EHR incentive payments should have been on a contingency based model rather than the grant model being utilized. Subsequent to the Company s receipt of the Staff s April 2012 letter and following additional consultation by management with the Company s independent registered public accounting firm and the Audit Committee of the Company s Board of Directors, SunLink concluded that, in light of Accounting Standards Codification 450-30, Gain Contingencies , (ASC 450-30) and the existing non-authoritative guidance, it will use the gain contingency based model for recognition of EHR payments rather than the grant model in order for the Company s financial statements to be reported in accordance with generally accepted accounting principles in the United States (GAAP). Accordingly, management determined and the Audit Committee concurred that the Company should report on Form 8-K (filed on May 8, 2012) that the Company s historical financial statements with respect to EHR incentive payments should no longer be relied upon and that the Company s applicable periodic reports should be amended and its historical financial statements restated to reflect the gain contingency based model for recognition of EHR incentive payments. Such restatements of SunLink s financial statements did not and will not affect the amount or the timing of receipts of past or future Medicare and Medicaid EHR incentive payments.

Based on the Public Company Accounting Oversight Board s Auditing Standard No. 2, an Audit of Internal Control over Financial Reporting Performed in Conjunction with Audit of Financial Statements , restatement of financial statements in prior filings with the SEC is said to be a strong indicator of the existence of a material weakness in the design or operation of internal control over financial reporting. The Company has concluded that, because its historical financial statements required restatement in light of ASC 450-30 such that treatment of the EHR incentive payments be based upon the contingency based model, a material weakness existed in the effectiveness of the Company s internal controls to provide reasonable assurance that its accounting for EHR incentive payments was in accordance with GAAP as of the date of the Company s annual report on Form 10-K for the period ended June 30, 2011, and as of the date of the Company s quarterly report on Form 10-Q for the period ended March 31, 2011, Form 10-Q for the period ended September 30, 2011 and quarterly report on Form 10-Q for the period ended December 30, 2011 and assuming it should have used the gain contingency based model, to this extent, its internal control over financial reporting was not effective.

This annual report (restated) does not include an attestation report of the Company s registered public accounting firm regarding internal control over financial reporting. Management s report was not subject to attestation by the Company s registered public accounting firm pursuant to rules of the SEC that permit the Company to provide only management s report in this annual report.

Changes in Internal Control Over Financial Reporting

Except as described above, there were no changes during the quarter ended June 30, 2011, or in the other periods referred to above, in our internal control over financial reporting or in other factors that materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Remediation of Material Weakness

As noted under Management s Report on Internal Control Over Financial Reporting above, we identified a material weakness in our accounting for EHR incentive payments as a result of our use of the grant method rather

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than the gain contingency method for accounting for EHR incentive payments. The change from the grant model to the gain contingency model required that previously issued financial statements of the Company be restated. The Company believes that it has implemented procedures which will remediate for future periods such material weakness in internal controls resulting by reason of our accounting for EHR incentive payments on the grant method rather than the gain contingency method.

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PART IV

Item 15. ***Exhibits, Financial Statement Schedules*.**

(a) (1) Financial Statements

The following consolidated financial statements of the Company and its subsidiaries are set forth in Item 8 of this Annual Report on Form 10-K/A.

Report of Independent Registered Public Accounting Firm.

Consolidated Balance Sheets June 30, 2011 and 2010.

Consolidated Statements of Earnings and Loss For the Years Ended June 30, 2011, 2010 and 2009.

Consolidated Statements of Shareholders Equity For the Years Ended June 30, 2011, 2010 and 2009.

Consolidated Statements of Cash Flows For the Years Ended June 30, 2011, 2010 and 2009.

Notes to Consolidated Financial Statements For the Years Ended June 30, 2011, 2010 and 2009.

(a) (2) Financial Statement Schedules

Report of Independent Registered Public Accounting Firm

Schedule II Valuation and Qualifying Accounts At page 61 of this Report

The information required to be submitted in Schedules I, III, IV and V for SunLink Health Systems, Inc. and its consolidated subsidiaries has either been shown in the financial statements or notes, or is not applicable or not required under Regulation S-X and, therefore, has been omitted.

(a) (3) See Item 15(b) below. Each management contract or compensatory plan or arrangement required to be filed as an Exhibit is identified below by an asterisk.

(b) Exhibits

The following exhibits are filed with this Form 10-K/A or incorporated herein by reference from the document set forth next to the exhibit in the list below. Exhibit numbers refer to Item 601 of Regulation S-K:

2.1	Asset Purchase Agreement, dated April 9, 2004, by and among Piedmont Mountainside Hospital, Inc., Piedmont Medical Center, Inc., Southern Health Corporation of Jasper, Inc., Southern Health Corporation, SunLink Healthcare Corp. and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 2.1 of the Company s Report on Form 8-K filed April 14, 2004). (Commission File No. 04731963)
3.1	Amended Articles of Incorporation of SunLink Health Systems, Inc. (incorporated by reference from Exhibit 3.1 of the Company s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.2	Code of Regulations of SunLink Health Systems, Inc., as amended (incorporated by reference from Exhibit 3.2 of the Company s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.3	Certificate of Amendment to Amend Article Fourth of the Amended Articles of Incorporation of SunLink Health Systems, Inc. dated February 13, 2004 (incorporated by reference from Exhibit 3.1 of the Company s Report on Form 10-Q for the quarter ended December

31, 2003). (Commission File No. 04610446)

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4.1	Shareholder Rights Agreement dated as of February 8, 2004, between SunLink Health Systems, Inc. and Wachovia Bank, N.A., as Rights Agent (incorporated by reference from Exhibit 4.1 of the Company s Report on Form 8-K filed February 10, 2004). (Commission File No. 04582922)
10.1*	2001 Long-Term Stock Option Plan (incorporated by reference from Exhibit 10.5 of the Company s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
10.2*	2001 Outside Directors Stock Ownership and Stock Option Plan (incorporated by reference from Exhibit 10.6 of the Company s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
10.3*	Employment Letter, dated April 30, 2001, by and between SunLink Health Systems, Inc. and Mark Stockslager (incorporated by reference from Exhibit 10.29 of SunLink s Form 10-Q for the quarter ended September 30, 2005). (Commission File No. 051197210)
10.4	Stock Purchase Agreement among SunLink Homecare Services, LLC, Carmichael s Cashway Pharmacy, Inc., Theodore S. Carmichael and Judy Chiasson Carmichael dated April 22, 2008 (the Carmichael Agreement) (incorporated by reference from Exhibit 10.28 of the Company s Report on Form 8-K filed April 29, 2008). (Commission File No. 08787122)
10.5*	Amended and Restated Employment Agreement, dated July 1, 2005, between Robert M. Thornton, Jr. and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.1 of the Company s Report on Form 8-K filed December 23, 2005). (Commission File No. 051285094)
10.6	Credit Agreement between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter Hospital LLC, Clanton Hospital LLC, Southern Health Corporation of Ellijay, Inc., Southern Health Corporation of Dahlonega, LLC, Southern Health Corporation of Houston, Inc., Southern Health Corporation of Jasper, Inc., HealthMont of Georgia, Inc., HealthMont, LLC, HealthMont of Missouri, LLC, SunLink Services, Inc., SunLink Homecare Services, LLC, KRUG Properties, Inc., Central Alabama Medical Associates, LLC, Dahlonega Clinic, LLC, Carmichael s Cashway Pharmacy, Inc., Carmichael s Nutritional Distributor, Inc., Breath of Life Home Health Equipment, Inc. and Chatham Credit Management III, LLC dated April 23, 2008 (incorporated by reference from Exhibit 10.29 of the Company s Report on Form 8-K filed April 29, 2008). (Commission File No. 08787122)
10.7*	2005 Equity Incentive Plan (incorporated by reference from Exhibit 99.1 of the Company s Registration Statement on Form S-8 filed September 20, 2006). (Commission File No. 061100389)
10.8	Agreement of Understanding, dated June 28, 2007, between Christopher H. B. Mills and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.2 of the Company s Report on Form 8-K filed July 16, 2007). (Commission File No. 07982325)
10.9*	Employment Letter dated September 30, 2002, by and between SunLink Healthcare Corp. and Jack M. Spurr, Jr. (incorporated by reference from Exhibit 10.27 of the Company s Report on Form 10-K dated September 24, 2007). (Commission File No. 017732454)
10.10	Amended and Restated Credit Agreement between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter Hospital LLC, Clanton Hospital LLC, Southern Health Corporation of Ellijay, Inc., Southern Health Corporation of Dahlonega, LLC, Southern Health Corporation of Houston, Inc., Southern Health Corporation of Jasper, Inc., HealthMont of Georgia, Inc., HealthMont, LLC, HealthMont of Missouri, LLC, SunLink Services, Inc., SunLink Homecare Services, LLC, KRUG Properties, Inc., Central Alabama Medical Associates, LLC, Dahlonega Clinic, LLC, Carmichael s Cashway Pharmacy, Inc., Carmichael s Nutritional Distributor, Inc., Breath of Life Home Health Equipment, Inc. and Chatham Credit Management III, LLC and Union Bank of California, N.A. dated August 1, 2008 (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2009). (Commission File No. 081091964)

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10.11*	Executive Bonus Plan for 2009 (incorporated by reference from Exhibit 10.13 of the Company s Report on Form 8-K filed November 18, 2008). (Commission File No. 081199137)
10.12	Letter Agreement regarding the Carmichael Agreement dated March 3, 2009 (incorporated by reference from Exhibit 99.1 to Current Report on Form 8-K filed March 30, 2009). (Commission File No. 09696285)
10.13	Limited Waiver Agreement Under Amended and Restated Credit Agreement between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter Hospital LLC, Clanton Hospital LLC, Southern Health Corporation of Ellijay, Inc., Southern Health Corporation of Dahlonega, LLC, Southern Health Corporation of Houston, Inc., Southern Health Corporation of Jasper, Inc., HealthMont of Georgia, Inc., HealthMont, LLC, HealthMont of Missouri, LLC, SunLink Services, Inc., SunLink Homecare Services, LLC, KRUG Properties, Inc., Central Alabama Medical Associates, LLC, Dahlonega Clinic, LLC, Carmichael s Cashway Pharmacy, Inc., Carmichael s Nutritional Distributor, Inc., Breath of Life Home Health Equipment, Inc. and Chatham Credit Management III, LLC dated September 27, 2010 (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2010). (Commission File No. 101119914)
10.14	Limited Consent and Modification of Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter Hospital LLC, Clanton Hospital LLC, Southern Health Corporation of Ellijay, Inc., Southern Health Corporation of Dahlonega, LLC, Southern Health Corporation of Houston, Inc., HealthMont of Georgia, Inc., HealthMont, LLC, HealthMont of Missouri, LLC, SunLink Services, Inc., SunLink ScriptsRX, LLC, Central Alabama Medical Associates, LLC, Dahlonega Clinic, LLC, Carmichael s Cashway Pharmacy, Inc., Carmichael s Nutritional Distributor, Inc., Breath of Life Home Health Equipment, Inc. and Chatham Credit Management III, LLC dated March 1, 2011 (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011). (Commission File No. 11842673)
10.15	Purchase and Sale Agreement between Central Alabama Medical Associates, LLC and Clanton Hospital, LLC dated March 1, 2011 (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2011). (Commission File No. 11842673)
10.16	Third Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter Hospital LLC, Clanton Hospital LLC, Southern Health Corporation of Ellijay, Inc., Southern Health Corporation of Dahlonega, LLC, Southern Health Corporation of Houston, Inc., HealthMont of Georgia, Inc., HealthMont, LLC, HealthMont of Missouri, LLC, SunLink Services, Inc., SunLink ScriptsRX, LLC, Central Alabama Medical Associates, LLC, Dahlonega Clinic, LLC, Carmichael s Cashway Pharmacy, Inc., Carmichael s Nutritional Distributor, Inc., Breath of Life Home Health Equipment, Inc., and Chatham Credit Management III, LLC dated July 28, 2011 (incorporated by reference from Exhibit 10.9 to Current Report on Form 8-K filed August 1, 2011). (Commission File No. 111000498)
10.17	Lease Agreement between Central Alabama Medical Associates, LLC and Clanton Hospital, LLC dated March 1, 2011 (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
10.18*	Management Services Agreement dated November 15, 2010, by and between SunLink Health Systems, Inc. and Centric Management Services Co., LLC (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
10.19*	Employment letter dated September 23, 2010 with an effective date of September 30, 2010, by and between SunLink ScriptsRx, LLC and Byron D. Finn (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
21.1	List of Subsidiaries (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
23.1	Consent of Cherry, Bekaert & Holland, L.L.P. ^

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31.1	Chief Executive Officer s Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934.^
31.2	Chief Financial Officer s Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934.^
32.1	Chief Executive Officer s Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.^
32.2	Chief Financial Officer s Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.^

* Management contract or compensatory plan or arrangement.
^ Filed herewith.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, SunLink Health Systems, Inc. has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized, on this 21st day of May, 2012.

SUNLINK HEALTH SYSTEMS, INC.

By: */s/ MARK J. STOCKSLAGER*
Mark J. Stockslager
Chief Financial Officer and Principal Accounting Officer (principal accounting officer)

May 21, 2012

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Shareholders of

SunLink Health Systems, Inc.

We have audited the consolidated financial statements of SunLink Health Systems, Inc. and subsidiaries (the Company) as of June 30, 2011 and 2010 and for each of the years in the three-year period ended June 30, 2011 and have issued our report thereon dated May 21, 2012; such consolidated financial statements and report are included elsewhere in this Form 10-K/A. Our audits also included the consolidated financial statement schedules of the Company, listed in Item 15 for each of the years in the three-year period ended June 30, 2011. These consolidated financial statement schedules are the responsibility of the Company s management. Our responsibility is to express an opinion based on our audits. In our opinion, such consolidated financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly in all material respects the information set forth therein.

/s/ Cherry, Bekaert & Holland, L.L.P.

Atlanta, Georgia

May 21, 2012

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SUNLINK HEALTH SYSTEMS, INC. AND SUBSIDIARIES

SCHEDULE II VALUATION AND QUALIFYING ACCOUNTS

(amounts in thousands)

Column A	Column B	Column C		Column D	Column E
Allowance for Doubtful Accounts	Balance at Beginning Of Year	Charged to Cost and Expenses	Currency Translation/ Acquisition/ (Disposition)	Deductions from Reserves	Balance at End of Year
Year Ended					
June 30, 2011	$ 14,725	$ 19,690	$ (2,305)	$ (19,793)	$ 12,317
Year Ended					
June 30, 2010	$ 12,795	$ 22,592	$	$ (20,662)	$ 14,725
Year Ended					
June 30, 2009	$ 14,138	$ 20,934	$	$ (22,277)	$ 12,795

Deferred Income Tax Asset Valuation Allowance	Balance at Beginning Of Year	Charged to Cost and Expenses/ (Benefit)	Currency Translation/ Acquisition/ (Disposition)	Deductions from Reserves	Balance at End of Year
Year Ended					
June 30, 2011	$ 1,350	$ 4,515	$	$ (3,778)	$ 2,087
Year Ended					
June 30, 2010	$ 2,724	$ (1,495)	$	$ 121	$ 1,350
Year Ended					
June 30, 2009	$ 2,810	$ (1,428)	$	$ 1,342	$ 2,724

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INDEX TO EXHIBITS

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10.11*	Executive Bonus Plan for 2009 (incorporated by reference from Exhibit 10.13 of the Company s Report on Form 8-K filed November 18, 2008). (Commission File No. 081199137)
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10.19*	Employment letter dated September 23, 2010 with an effective date of September 30, 2010, by and between SunLink ScriptsRx, LLC and Byron D. Finn (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
21.1	List of Subsidiaries (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
23.1	Consent of Cherry, Bekaert & Holland, L.L.P.^
31.1	Chief Executive Officer s Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934.^
31.2	Chief Financial Officer s Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934.^
32.1	Chief Executive Officer s Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.^
32.2	Chief Financial Officer s Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.^

* Management contract or compensatory plan or arrangement.
^ Filed herewith.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

Board of Directors and Shareholders of

SunLink Health Systems, Inc.

We have audited the accompanying consolidated balance sheets of SunLink Health Systems, Inc. and subsidiaries (the Company) as of June 30, 2011 and 2010 and the related consolidated statements of operations, shareholders equity, and cash flows for each of the years in the three-year period ended June 30, 2011. These consolidated financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company s internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of the Company as of June 30, 2011 and 2010, and the consolidated results of its operations and its cash flows for each of the years in the three-year period ended June 30, 2011, in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1, the previously issued consolidated financial statements as of and for the year ended June 30, 2011 were restated for the correction of an error.

/s/ Cherry, Bekaert & Holland, L.L.P.

Atlanta, Georgia

May 21, 2012

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SUNLINK HEALTH SYSTEMS, INC.

CONSOLIDATED BALANCE SHEETS

JUNE 30, 2011 AND 2010

	2011 (Restated See Note 1)	2010
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 7,250	$ 1,704
Receivables net	16,302	16,036
Inventory	4,371	4,206
Income tax receivable	1,526	345
Deferred income tax asset	8,846	6,030
Medicaid Electronic Health Records incentive reimbursement receivable	277	
Prepaid expense and other	4,356	4,016
Current assets of Memorial Hospital of Adel	437	449
Current assets of Chilton Medical Center		1,848
Total current assets	43,365	34,634
PROPERTY, PLANT AND EQUIPMENT At cost		
Land	1,949	1,949
Buildings and improvements	26,509	26,123
Equipment and fixtures	37,509	35,605
	65,967	63,677
Less accumulated depreciation	32,283	27,388
Property, plant and equipment net	33,684	36,289
NONCURRENT ASSETS:		
Intangible assets net	3,477	11,386
Goodwill	1,392	7,440
Deferred income tax asset	2,786	
Other noncurrent assets	346	1,700
Noncurrent assets of Memorial Hospital of Adel	6,780	7,041
Total noncurrent assets	14,781	27,567
TOTAL ASSETS	$ 91,830	$ 98,490
LIABILITIES AND SHAREHOLDERS EQUITY		
CURRENT LIABILITIES:		
Accounts payable	$ 7,509	$ 7,605
Revolving advances	5,300	
Current maturities of long-term debt	1,814	1,797
Current maturities of subordinated long-term debt	300	300
Accrued payroll and related taxes	5,064	4,734
Deferred gain Medicare Electronic Health Records incentives	8,521	
Income taxes		607
Current liabilities of Chilton Medical Center		1,704
Other accrued expenses	2,824	2,359

Total current liabilities	31,332	19,106
LONG-TERM LIABILITIES:		
Long-term debt	27,441	29,090
Subordinated long-term debt	2,197	2,250
Noncurrent deferred income tax liabilities		1,625
Noncurrent liability for professional liability risks	3,583	2,956
Other noncurrent liabilities	1,209	771
Total long-term liabilities	34,430	36,692
COMMITMENTS AND CONTINGENCIES		
SHAREHOLDERS EQUITY:		
Preferred Shares, authorized and unissued, 2,000 shares		
Common Shares, no par value; authorized, 12,000 shares; issued and outstanding, 8,120 shares at June 30, 2011 and 8,079 shares at June 30, 2010	4,060	4,039
Additional paid-in capital	11,751	11,701
Retained earnings	10,462	26,565
Accumulated other comprehensive loss	(278)	(301)
Total Parent Company Shareholders Equity	25,995	42,004
Noncontrolling interest	73	688
Total Shareholders Equity	26,068	42,692
TOTAL LIABILITIES AND SHAREHOLDERS EQUITY	$ 91,830	$ 98,490

See notes to consolidated financial statements.

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SUNLINK HEALTH SYSTEMS, INC.

CONSOLIDATED STATEMENTS OF EARNINGS AND LOSS

FOR THE YEARS ENDED JUNE 30, 2011, 2010 AND 2009

(All amounts in thousands, except per share amounts)

	Years Ended		
	June 30, 2011 (Restated See Note 1)	June 30, 2010	June 30, 2009
Net revenues	$ 154,380	$ 166,322	$ 162,961
Costs and expenses:			
Cost of goods sold	27,835	29,539	31,766
Salaries, wages and benefits	63,846	65,031	63,202
Provision for bad debts	16,841	20,364	16,901
Supplies	11,083	12,267	11,237
Purchased services	10,031	10,207	9,367
Other operating expenses	19,671	18,782	16,375
Rents and leases expense	2,903	2,691	2,593
Impairment of goodwill and intangible assets	13,347		
Impairment of construction in progress		1,202	433
Depreciation and amortization	5,697	6,124	6,245
Medicaid Electronic Health Records incentives	(277)		
Gain on sale of Home Health Businesses		(2,342)	
Operating profit (loss)	(16,597)	2,457	4,842
Other income (expense):			
Interest expense	(7,433)	(3,471)	(3,765)
Interest income	5	14	50
Gain on sale of assets			180
Earnings (loss) from continuing operations before income taxes	(24,025)	(1,000)	1,307
Income tax expense (benefit)	(8,609)	(578)	696
Earnings (loss) from continuing operations	(15,416)	(422)	611
Earnings (loss) from discontinued operations, net of income taxes	(687)	524	301
Net earnings (loss)	$ (16,103)	$ 102	$ 912
Earnings (loss) per share:			
Continuing operations:			
Basic	$ (1.90)	$ (0.05)	$ 0.08
Diluted	$ (1.90)	$ (0.05)	$ 0.08
Discontinued operations:			

Basic	$ (0.08)	$ 0.07	$ 0.04
Diluted	$ (0.08)	$ 0.07	$ 0.04
Net earnings (loss):			
Basic	$ (1.99)	$ 0.01	$ 0.11
Diluted	$ (1.99)	$ 0.01	$ 0.11
Weighted-average common shares outstanding:			
Basic	8,094	8,052	7,975
Diluted	8,094	8,052	8,019

See notes to consolidated financial statements.

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SUNLINK HEALTH SYSTEMS, INC.

CONSOLIDATED STATEMENTS OF SHAREHOLDERS EQUITY

FOR THE YEARS ENDED JUNE 30, 2011, 2010 AND 2009

(All amounts in thousands)

	Common Shares		Additional Paid-in	Retained	Accumulated Other Comprehensive Income	Noncontrolling	Total Shareholders
	Shares	Amount	Capital	Earnings	(Loss)	Interest	Equity
JULY 1, 2008	7,932	$ 3,966	$ 11,310	$ 25,551	$ (583)	$ 615	$ 40,859
Net earnings				912			912
Foreign currency translation adjustment					281		281
Minimum pension liability adjustment, net of tax of $12					(35)		(35)
Total comprehensive income							1,158
Share-based compensation			190				190
Common shares issued	118	59	126				185
JUNE 30, 2009	8,050	4,025	11,626	26,463	(337)	615	42,392
Net earnings				102			102
Foreign currency translation adjustment					46		46
Minimum pension liability adjustment, net of tax of $21					(10)		(10)
Total comprehensive income							138
Share-based compensation			40				40
Common shares issued	29	14	35				49
Sale of noncontrolling interest						73	73
JUNE 30, 2010	8,079	4,039	11,701	26,565	(301)	688	42,692
Net loss (Restated See Note 1)				(16,103)			(16,103)
Minimum pension liability adjustment, net of tax of $6					23		23
Total comprehensive income (Restated See Note 1)							(16,080)
Share-based compensation			6				6
Common shares issued	41	21	44				65
Change in noncontrolling interest						(615)	(615)
JUNE 30, 2011 (Restated See Note 1)	8,120	$ 4,060	$ 11,751	$ 10,462	$ (278)	$ 73	$ 26,068

See notes to consolidated financial statements.

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SUNLINK HEALTH SYSTEMS, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED JUNE 30, 2011, 2010 AND 2009

(All amounts in thousands)

	Years Ended		
	June 30, 2011 (Restated See Note 1)	June 30, 2010	June 30, 2009
CASH FLOWS FROM OPERATING ACTIVITIES			
Net earnings (loss)	(16,103)	102	912
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities:			
Depreciation and amortization	5,697	6,124	6,245
Stock-based compensation	6	41	190
Impairment of goodwill and intangible assets	13,347		
Impairment of construction in process		1,202	433
Gain on sale of Chilton Medical Center	(438)		
Gain on sale of Home Health businesses		(2,342)	
Gain on sale of assets			(180)
Change in assets and liabilities:			
Receivables	(265)	3,948	(1,306)
Inventory	(164)	(57)	(78)
Prepaid expenses and other assets	1,250	(1,104)	127
Accounts payable and accrued expenses	1,775	(1,052)	(100)
Income taxes	(1,788)	(1,058)	1,110
Deferred income taxes	(7,227)	(735)	(1,353)
Third-party payor settlements	210	(617)	(1,529)
Electronic Health Records deferred gain	8,244		
Net activities of discontinued operations	235	(524)	(41)
Net cash provided by operating activities	4,779	3,928	4,430
CASH FLOWS FROM INVESTING ACTIVITIES			
Expenditures for property, plant and equipment continuing operations	(2,347)	(2,309)	(1,305)
Expenditures for property, plant and equipment discontinued operations	(293)	(193)	(266)
Proceeds from sale of Home Health businesses		3,300	
Proceeds from sale of property, plant and equipment			522
Proceeds from sale of noncontrolling interest		73	
Net cash provided by (used in) investing activities	(2,640)	871	(1,049)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Proceeds from issuance of common shares	65	49	185
Payment of long-term debt	(1,958)	(2,108)	(2,418)
Revolving advances, net	5,300	(3,400)	(500)
Net cash provided by (used in) financing activities	3,407	(5,459)	(2,733)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	5,546	(660)	648
CASH AND CASH EQUIVALENTS:			
Beginning of year	1,704	2,364	1,716

End of year	$ 7,250	$ 1,704	$ 2,364
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid for:			
Income taxes	$ 356	$ 1,548	$ 1,358
Interest	$ 4,025	$ 3,103	$ 3,395
Non-cash investing and financing activities:			
Assets acquired under capital lease obligation	$ 205	$	$ 133
Long-term debt issued as payment-in-kind for interest payable	$ 247	$	$

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SUNLINK HEALTH SYSTEMS, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

AS OF AND FOR THE YEARS ENDED JUNE 30, 2011, 2010 and 2009

(All amounts in thousands, except share and per share amounts)

1. BASIS OF PRESENTATION AND RESTATEMENT

SunLink Health Systems, Inc. (we , our , us , SunLink or the Company) is filing this Amendment No. 1 of Form 10-K/A to our Form 10-K to reflect the restatement of our previously issued consolidated financial statements for the fiscal year ended June 30, 2011 in response to comments issued by the U.S. Securities and Exchange Commission (SEC) and to clarify certain prior disclosures.

On May 7, 2012, the Board of Directors and Audit Committee of SunLink Health concluded that, as a results of comments issued by the SEC on its Form 10-K for the fiscal year ended June 30, 2011, the financial statements for the fiscal year ended June 30, 2011 should no longer be relied upon in light of existing non-authoritative guidance and Accounting Standards Codification 450-30, Gain Contingencies , (ASC 450-30) that Medicare and Medicaid incentive payments for implementation of electronic health records (EHR) technology be accounted for on the basis of the gain contingency accounting model rather than a grant based accounting model as employed by SunLink with respect to such payments in fiscal quarters ending prior to December 31, 2011. As a result, the Company is restating its financial statements for the fiscal year ended June 30, 2011. The restatement of financial statements does not affect the amount or the timing of past or future Medicare and Medicaid incentive payments.

In an unrelated matter, the amended reports listed above will reflect the retroactive reclassification of financial information with respect to the reclassification of the Company s Memorial Hospital of Adel to discontinued operations (Discontinued Operations Reclassification) as a result of the Company s decision in the quarter ended March 31, 2012 to sell such operations and the entry by the Company and its HealthMont of Georgia, Inc. subsidiary, on March 8, 2012, into an Asset Purchase Agreement by and among HealthMont of Georgia, Inc., SunLink and Hospital Authority of Tift County, Georgia (Buyer) effective as of March 1, 2012 (the Adel Sale Agreement) to sell substantially all of the assets of the Company s owned Memorial Hospital of Adel and Memorial Convalescent Center (Adel) to the Buyer for approximately $8,300.

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The following table sets forth the effects of the restatement adjustments and discontinued operations reclassification on line items within our previously reported consolidated balance sheet as of June 30, 2011:

	Fiscal Year Ended June 30, 2011			
	As Previously Reported	Restatement Adjustments	Discontinued Operations Reclassification	As Restated
CURRENT ASSETS:				
Cash and cash equivalents	$ 7,250	$	$	$ 7,250
Receivables net	16,302			16,302
Inventory	4,717		(346)	4,371
Income tax receivable	1,526			1,526
Net current assets of Memorial Hospital of Adel			437	437
Deferred income tax asset	5,586	3,260		8,846
Medicaid Electronic Health Records incentive reimbursement receivable	1,243	(966)		277
Prepaid expense and other	4,447		(91)	4,356
Total current assets	41,071	2,294		43,365
PROPERTY, PLANT AND EQUIPMENT At cost				
Land	2,229		(280)	1,949
Buildings and improvements	32,365		(5,856)	26,509
Equipment and fixtures	40,428		(2,919)	37,509
	75,022		(9,055)	65,967
Less accumulated depreciation	36,503		(4,220)	32,283
Property, plant and equipment net	38,519		(4,835)	33,684
NONCURRENT ASSETS:				
Intangible assets net	3,838		(361)	3,477
Goodwill	2,976		(2,515)	461
Net noncurrent assets of Memorial Hospital of Adel			7,711	7,711
Deferred income tax asset	2,786			2,786
Other noncurrent assets	346			346
Total noncurrent assets	9,946		4,835	14,781
TOTAL ASSETS	$ 89,536	$ 2,294	$	$ 91,830
LIABILITIES AND SHAREHOLDERS EQUITY				
CURRENT LIABILITIES:				
Accounts payable	$ 7,509	$	$	$ 7,509
Revolving advances	5,300			5,300
Current maturities of long-term debt	1,814			1,814
Current maturities of subordinated long-term debt	300			300
Accrued payroll and related taxes	5,064			5,064
Deferred gain Medicare Electronic Health Records incentives	839	7,682		8,521
Income taxes				
Current liabilities of Chilton Medical Center				
Other accrued expenses	2,824			2,824
Total current liabilities	23,650	7,682		31,332
LONG-TERM LIABILITIES:				

Long-term debt	27,441			27,441
Subordinated long-term debt	2,197			2,197
Noncurrent deferred income tax liabilities				
Noncurrent liability for professional liability risks	3,583			3,583
Other noncurrent liabilities	1,209			1,209
Total long-term liabilities	34,430			34,430
COMMITMENTS AND CONTINGENCIES				
SHAREHOLDERS EQUITY:				
Preferred Shares, authorized and unissued, 2,000 shares				
Common Shares, no par value; authorized, 12,000 shares; issued and outstanding, 8,120 shares at June 30, 2011 and 8,079 shares at June 30, 2010	4,060			4,060
Additional paid-in capital	11,751			11,751
Retained earnings	15,850	(5,388)		10,462
Accumulated other comprehensive loss	(278)			(278)
Total Parent Company Shareholders Equity	31,383	(5,388)		25,995
Noncontrolling interest	73			73
Total Shareholders Equity	31,456	(5,388)		26,068
TOTAL LIABILITIES AND SHAREHOLDERS EQUITY	$ 89,536	$ 2,294	$	$ 91,830

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The impact of the restatement adjustments and discontinued operations reclassification on the Company s previously reported consolidated statement of earnings and loss for the fiscal year ended June 30, 2011 is shown in the following table (in thousands, except per share data):

	Fiscal Year Ended June 30, 2011			
	As Previously Reported	Restatement Adjustments	Discontinued Operations Reclassification	As Restated
Net revenues	$ 181,161	$ (8,925)	$ (17,856)	$ 154,380
Costs and expenses:				
Cost of goods sold	27,835			27,835
Salaries, wages and benefits	72,711		(8,865)	63,846
Provision for bad debts	19,690		(2,849)	16,841
Supplies	13,040		(1,957)	11,083
Purchased services	11,426		(1,395)	10,031
Other operating expenses	22,440		(2,769)	19,671
Rents and leases expense	3,172		(269)	2,903
Impairment of goodwill and intangible assets	13,347			13,347
Medicaid Electronic Health Records incentives		(277)		(277)
Depreciation and amortization	6,231		(534)	5,697
Operating loss	(8,731)	(8,648)	782	(16,597)
Other income (expense):				
Interest expense	(7,433)			(7,433)
Interest income	5			5
Loss from continuing operations before income taxes	(16,159)	(8,648)	782	(24,025)
Income tax benefit	(5,607)	(3,260)	258	(8,609)
Loss from continuing operations	(10,552)	(5,388)	524	(15,416)
Loss from discontinued operations, net of income taxes	(163)		(524)	(687)
Net loss	$ (10,715)	$ (5,388)	$	$ (16,103)
Loss per share:				
Continuing operations:				
Basic	$ (1.30)	$ (0.67)	$ 0.06	$ (1.90)
Diluted	$ (1.30)	$ (0.67)	$ 0.06	$ (1.90)
Discontinued operations:				
Basic	$ (0.02)	$	$ (0.06)	$ (0.08)
Diluted	$ (0.02)	$	$ (0.06)	$ (0.08)
Net loss:				
Basic	$ (1.32)	$ (0.67)	$	$ (1.99)
Diluted	$ (1.32)	$ (0.67)	$	$ (1.99)

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The following table presents the impact of the restatement adjustments and on the Company s previously reported consolidated statement of shareholders equity for the fiscal year ended June 30, 2011:

	Common Shares		Additional Paid-in	Retained	Accumulated Other Comprehensive Income	Noncontrolling	Total Shareholders
	Shares	Amount	Capital	Earnings	(Loss)	Interest	Equity
JUNE 30, 2010	8,079	4,039	11,701	26,565	(301)	688	42,692
Net loss (as previously reported)				(10,715)			(10,715)
Restatement adjustment				(5,388)			(5,388)
Minimum pension liability adjustment, net of tax of $6					23		23
Total comprehensive income							(16,080)
Share-based compensation			6				6
Common shares issued	41	21	44				65
Change in noncontrolling interest						(615)	(615)
JUNE 30, 2011	8,120	$ 4,060	$ 11,751	$ 10,462	$ (278)	$ 73	$ 26,068

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The following table presents the impact of the restatement adjustments and discontinued operations reclassification on the Company s previously reported consolidated statement of cash flows for the fiscal year ended June 30, 2011:

	Fiscal Year Ended June 30, 2011			
	As Previously Reported	Restatement Adjustments	Discontinued Operations Reclassification	As Restated
CASH FLOWS FROM OPERATING ACTIVITIES				
Net loss	(10,715)	(5,388)		(16,103)
Adjustments to reconcile net loss to net cash provided by operating activities:				
Depreciation and amortization	6,231		(534)	5,697
Stock-based compensation	6			6
Impairment of goodwill and intangible assets	13,347			13,347
Gain on sale of Chilton Medical Center	(438)			(438)
Change in assets and liabilities:				
Receivables	(265)			(265)
Inventory	(206)		42	(164)
Prepaid expenses and other assets	849		401	1,250
Accounts payable and accrued expenses	1,775			1,775
Income taxes	(1,788)			(1,788)
Deferred income taxes	(3,967)	(3,260)		(7,227)
Third-party payor settlements	(194)	404		210
Electronic Health Records deferred gain		8,244		8,244
Net activities of discontinued operations	144		91	235
Net cash provided by operating activities	4,779			4,779
CASH FLOWS USED IN INVESTING ACTIVITIES:	(2,640)			(2,640)
CASH FLOWS FROM FINANCING ACTIVITIES:	3,407			3,407
NET INCREASE IN CASH AND CASH EQUIVALENTS	5,546			5,546
CASH AND CASH EQUIVALENTS:				
Beginning of year	1,704			1,704
End of year	$ 7,250	$	$	$ 7,250

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2. BUSINESS OPERATIONS

SunLink Health Systems, Inc. (SunLink , we , our , ours , us or the Company) is a provider of healthcare services in certain markets in the U States. SunLink s business is composed of two business segments:

Healthcare Facilities, which consists of

- Our five community hospitals which have a total of 282 licensed beds;
- Our three nursing homes, each of which is located adjacent to a corresponding SunLink community hospital which have a total of 166 licensed beds; and
- Our one home health agency which operates for a corresponding SunLink community hospital.

Specialty Pharmacy, which consists of

- Specialty pharmacy services;
- Durable medical equipment;
- Institutional pharmacy services; and
- Retail pharmacy products and services, all of which are conducted in rural markets.

SunLink has conducted its healthcare facilities business since 2001 and its specialty pharmacy operations since April 2008. Our Specialty Pharmacy Segment currently is operated through Carmichael s Cashway Pharmacy, Inc. (Carmichael), a subsidiary of our SunLink ScriptsRx, LLC subsidiary, and is composed of a specialty pharmacy business acquired in April 2008 with four service lines.

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

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

B Warrants each of which will entitle the holder for three years to buy one SunLink common share at an exercise price of $6.50.

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

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

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Upon completion of the mergers, the combined company would expect to change its name to Foundation SunLink Healthcare Affiliates, Inc. In addition, it is anticipated that two persons designated by Foundation/New Age will join the board of directors of SunLink. Foundation SunLink is intended to be a premier healthcare facilities company positioned to respond to the changing marketplace developing under healthcare reform. Foundation SunLink s mission will be to more closely align the interests of physicians, hospitals and related healthcare facilities to improve the quality of care and control healthcare costs in communities it serves. It is anticipated that Foundation SunLink will focus on growth through physician-centric hospitals, surgery centers and related ancillary service providers, including its existing hospitals and surgery centers, plus the aggressive acquisition and development of additional physician-centric hospitals, surgery centers and ancillary service providers nationwide. No definitive agreement was executed in relation to the contemplated mergers.

On November 8, 2011, SunLink and Foundation announced that they had ended their previously announced merger discussions. SunLink s Board and management concluded that the business plan that the Company has adopted is fundamentally sound and has determined to focus the Company s strategic efforts on enhancing its existing hospital portfolio and on pursuing potential hospital acquisitions. SunLink is committed to enhancing shareholder value while maintaining high standards of responsibility to its patients, employees and the communities it serves and will continue to pursue strategic alternatives consistent with that commitment.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation The consolidated financial statements include the accounts of SunLink and its domestic and foreign subsidiaries, all of which are 100% owned except for one pharmacy segment subsidiary that is 51% owned. All significant intercompany transactions and balances have been eliminated.

Management Estimates The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Some of the more significant estimates made by management involve reserves for adjustments to net patient service revenues, evaluation of the recoverability of assets, including accounts receivable and intangible assets, and the assessment of litigation and contingencies, including income taxes and related tax asset valuation allowances, all as discussed in more detail in the remainder of these notes to the consolidated financial statements. Actual results could differ materially from these estimates.

Net Patient Service Revenue SunLink has agreements with third-party payors that provide for payments at amounts different from established charges. Payment arrangements vary and include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Patient service revenues are reported as services are rendered at the estimated net realizable amounts from patients, third-party payors, and others. Estimated net realizable amounts are estimated based upon contracts with third-party payors, published reimbursement rates, and historical reimbursement percentages pertaining to each payor type. Estimated reductions in revenues to reflect agreements with third-party payors and estimated retroactive adjustments under such reimbursement agreements are accrued during the period the related services are rendered and are adjusted in future periods as interim and final settlements are determined. Significant changes in reimbursement levels for services under government and private programs could significantly impact the estimates used to accrue such revenue deductions. At June 30, 2011, there were no material claims or disputes with third-party payors.

Charity Care SunLink provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because SunLink does not pursue collection of amounts determined to qualify as charity, they are not reported as revenue. SunLink provided $6,545, $4,238, and $5,477, of charity care in the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

Concentrations of Credit Risk SunLink grants unsecured credit to its patients, most of who reside in the service area of SunLink s facilities and are insured under third-party agreements. Although SunLink s two Georgia facilities generated approximately 51%, 52%, and 51% of gross revenues for the years ended June 30, 2011, 2010 and 2009, respectively, because of the geographic diversity of SunLink s facilities and nongovernmental third-party payors, Medicare and Medicaid accounts represent SunLink s only significant concentrations of credit risk. For SunLink s Healthcare Facilities Segment, Medicare net revenues were approximately 41%, 39%, and 40% of net revenues for the years ended June 30, 2011, 2010 and 2009, respectively. For SunLink s Healthcare Facilities Segment, Medicaid was approximately 13%, 12%, and 14% of net revenues for the years ended June 30, 2011, 2010 and 2009, respectively. For SunLink s Healthcare Facilities Segment, Medicare receivables were approximately 36% and 39% of receivables net at June 30, 2011 and 2010, respectively, while Medicaid receivables were approximately 26% and 24% of receivables net at June 30, 2011 and 2010, respectively.

Cash and Cash Equivalents Cash and cash equivalents consist of highly liquid financial instruments, which have original maturities of three months or less when purchased. Cash is deposited with commercial banks and may have deposits totaling amounts in excess of the federally insured limits from time to time.

Inventory Inventory consists of medical and pharmacy supplies. Medical supplies are valued at the lower of cost or market, using the first-in, first-out method. Pharmacy supplies are stated at the lower of cost (standard cost method), or market. Use of this method does not result in a material difference from the methods required by generally accepted accounting principles in the United States of America.

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Allowance for Doubtful Accounts Substantially all of SunLink s receivables result from providing healthcare services to hospital facility patients and from providing pharmacy services and products to customers. Accounts receivable are reduced by an allowance for doubtful accounts estimated to become uncollectible in the future. For its Healthcare Facilities, the Company calculates an allowance percentage based generally upon its historical collection experience for each type of payor. The allowance amount is computed by applying allowance percentages to receivable amounts included in specific payor categories. Significant changes in reimbursement levels for services under government and private programs could significantly impact the estimates used to determine the allowance for doubtful accounts. Accounts receivable are written off after all collection efforts have failed, normally within 120 days after the date of discharge of the patient or service to the patient or customer. For its Pharmacy Operations, the Company calculates an allowance percentage based on past credit history with customers and their current financial condition. Accounts receivable are written off against the allowance for doubtful accounts when they are deemed uncollectible.

Medicare and Medicaid Electronic Health Records Incentives The Company accounts for EHR incentive payments in accordance with ASC 450-30. In accordance with ASC 450-30, the Company recognizes EHR incentive payments when all contingencies relating to the incentive payment have been satisfied and compliance with the EHR meaningful use criteria have been attested to. For recognition of Medicaid EHR incentive payments, recognition of the payments will be at the time of attestation to EHR meaningful use criteria since Medicaid payments for the states in which the Company operates are based upon historical cost report information with no subsequent payment adjustment. However, for Medicare EHR incentive payments, recognition is being deferred until both the Medicare federal fiscal year during which EHR meaningful use was demonstrated ends and the cost report information utilized to determine the final amount of reimbursement is known. 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 Centers for Medicare and Medicaid Services.

Incentive payments for Medicare meaningful use will be recognized once the Medicare EHR meaningful use attestation has been successfully completed and all information utilized to calculate the amounts of incentive reimbursement payments is known. Incentive payments for Medicaid meaningful use will be recognized once the Medicaid EHR meaningful use attestation has been successfully completed and all information utilized to calculate the amounts of incentive reimbursement payments is known. Medicaid EHR incentive payments will be recognized as gains upon completion of successful attestation of meaningful use and notification of the payment amount is verified with Medicaid.

Property, Plant, and Equipment Property, plant, and equipment, including equipment subject to capital leases, are recorded at cost. Depreciation is recognized over the estimated useful lives of the assets, which range from 3 to 45 years, on a straight-line basis. Generally, furniture and fixtures are depreciated over 5 to 10 years, machinery and equipment over 10 years, and buildings over 25 to 45 years. Leasehold improvements and leased machinery and equipment are depreciated over the lease term or estimated useful life, whichever is shorter, of the asset and range from 5 to 15 years. For our Specialty Pharmacy Segment, durable medical equipment is depreciated over 3 years. Expenditures for major renewals and replacements are capitalized. Expenditures for maintenance and repairs are charged to operating expense as incurred. When property items are retired or otherwise disposed of, amounts applicable to such items are removed from the related asset and accumulated depreciation accounts and any resulting gain or loss is credited or charged to income. Depreciation expense totaled $5,526, $5,337, and $5,362, for the years ended June 30, 2011, 2010 and 2009, respectively.

Risk Management SunLink is exposed to various risks of loss from medical malpractice and other claims and casualties; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters (including earthquakes and hurricanes); and employee health, dental and accident benefits. Commercial insurance coverage is purchased for a portion of claims arising from such matters.

When, in management s judgment, claims are sufficiently identified, a liability is accrued for estimated costs and losses under such claims, net of estimated insurance recoveries except where applicable laws, rules or regulations require us to report the gross estimate of potential or estimated losses.

By virtue of the acquisition of its initial six hospitals, SunLink assumed responsibility for professional liability claims reported after the February 1, 2001 acquisition date and the previous owner retained responsibility for all known and filed claims prior to the acquisition date. SunLink purchased claims-made commercial insurance for acts prior to and after the acquisition date. The recorded liability for professional liability risks includes an estimate of the liability for claims incurred prior to February 1, 2001, but reported after February 1, 2001, and for claims incurred after February 1, 2001. These amounts are based on actuarially determined amounts.

In connection with the acquisition of HealthMont LLC (HealthMont) and its two hospitals, SunLink assumed responsibility for all professional liability claims. HealthMont had purchased claims-made commercial insurance for claims made prior to the acquisition and SunLink purchased claims-made commercial insurance for claims made after the acquisition. The recorded liability for professional liability risks includes an estimate of liability for claims assumed at the acquisition and for claims incurred after the acquisition. These amounts are based on actuarially

determined amounts.

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The Company self-insures for workers compensation risk. The estimated liability for workers compensation risk includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. Since October 1, 2006, the Company is self-insured for employee health risks. The estimated liability for employee health risk includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

The Company accrues an estimate of losses resulting from workers compensation and professional liability claims to the extent they are not covered by insurance. These accruals are estimated quarterly based upon management s review of claims reported and historical loss data.

The Company records a liability pertaining to pending litigation if it is probable a loss has been incurred and accrues the most likely amount of loss based on the information available. If no amount within the range of losses estimated from the information available is more likely than any other amount in the range of loss, the minimum amount in the range of loss is accrued. Because of uncertainties surrounding the nature of litigation and the ultimate liability to SunLink, if any, we revise estimated losses as additional facts become known.

Long-lived Assets SunLink periodically assesses the recoverability of assets based on its expectations of future profitability and the undiscounted cash flows of the related operations and, when circumstances dictate, adjusts the carrying value of the asset to estimated fair value. These factors, along with management s plans with respect to the operations, are considered in assessing the recoverability of long-lived assets.

Goodwill and Intangibles Goodwill represents the cost of acquired businesses in excess of fair value of identifiable tangible and intangible net assets purchased. Goodwill has an indefinite life and is not subject to periodic amortization. However, goodwill is tested at least annually for impairment, using a fair value methodology, in lieu of amortization. Definite-life intangible assets are amortized on a straight-line basis over their estimated useful lives, generally for periods ranging from 2 to 30 years. SunLink evaluates the reasonableness of the useful lives of intangible assets and they are tested for impairment as conditions warrant.

Income Taxes SunLink accounts for income taxes using an asset and liability approach and the recognition of deferred tax assets and liabilities for expected future tax consequences. SunLink considers all expected future events other than proposed enactments of changes in the income tax law or rates. When management determines that it is more likely than not that a portion of or none of the net deferred tax asset will be realized through future taxable earnings or implementation of tax planning strategies, management provides a valuation allowance for the portion not expected to be realized.

Share-Based Compensation The Company issues common share options to key employees and directors under various shareholder-approved plans. Share-based compensation expense of $6, $40 and $190 for the fiscal years ended June 30, 2011, 2010 and 2009, respectively, was recorded in salaries, wages and benefits expense for share options issued to employees and directors of the Company. The fair value of the share options was estimated using the Black-Scholes option pricing model. The historical volatility is used to calculate the estimated volatility in this model.

Fair Value of Financial Instruments The recorded values of cash, receivables, and payables approximate their fair values because of the relatively short maturity of these instruments. Similarly, the fair value of SunLink s long-term debt is estimated to approximate its recorded values due to its current variable interest rate.

Earnings (Loss) per Share Earnings (loss) per common share is based on the weighted-average number of common shares and dilutive common share equivalents outstanding for each period presented, including vested and unvested shares issued under SunLink s 1995 Incentive Stock Option Plan, 2001 Long-Term Stock Option Plan, 2001 Outside Directors Stock Ownership and Stock Option Plan and the 2005 Equity Incentive Plan. Common share equivalents represent the dilutive effect of the assumed exercise of the outstanding stock options.

Recent Accounting Pronouncements In July 2011, the FASB issued ASU 2011-7, Health Care Entities (Topic 954) Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities (ASU 2011-7). In accordance with ASU 2011-7, the Company will be required to present its provision for doubtful accounts related to patient service revenue as a deduction from revenue, similar to contractual discounts. Accordingly, the Company s revenues will be required to be reported net of both contractual discounts as well as its provision for doubtful accounts related to patient service revenues. Additionally, ASU 2011-7 will require the Company to make certain additional disclosures designed to help users understand how contractual discounts and bad debts affect recorded revenue in both interim and annual financial statements. ASU 2011-7 is required to be applied retrospectively and is effective for public companies for fiscal years beginning after December 15, 2011, and interim periods within those fiscal years. Early adoption is permitted. The adoption of ASU 2011-7 is not expected to impact the Company s financial position, results of operations or cash flows although it will change the presentation of the Company s revenues on its statements of earnings as well as requiring additional disclosures.

In June 2011, the FASB issued ASU 2011-5, Comprehensive Income (Topic 220) Presentation of Comprehensive Income (ASU 2011-5). ASU 2011-5 eliminates the Company s currently elected option to present components of other comprehensive income as part of the statement of changes in stockholders equity. Instead, ASU 2011-5 requires that all non-owner changes in stockholders equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive

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statements. ASU 2011-5 is required to be applied retrospectively and is effective for public companies for fiscal years beginning after December 15, 2011, and interim periods within those fiscal years. Early adoption is permitted. The Company anticipates applying the provisions of ASU 2011-5 for its fiscal year ending June 30, 2012. The adoption of ASU 2011-5 is not expected to impact the Company s financial position, results of operations or cash flows prospectively.

Reclassifications Certain prior year amounts have been reclassified in our consolidated financial statements to conform to current year classifications. These reclassifications include reclassifying net current assets and net current liabilities of our formerly owned Chilton Medical Center (see Note 5 Discontinued operations) the June 30, 2010 consolidated balance sheets and results of operations of our formerly owned Chilton Medical Center from continuing operations to discontinued operations in the consolidated statement of earnings for the fiscal years ended June 30, 2010 and 2009. These reclassifications also include reclassifying net current assets and net noncurrent assets of Memorial Hospital of Adel and Memorial Convalescent Center (see Note 5 Discontinued operations) on the June 30, 2011 and 2010 consolidated balance sheets and results of operations from continuing operations to discontinued operations in the consolidated statement of earnings for the fiscal years ended June 30, 2011, 2010 and 2009.

4. SUBSEQUENT EVENTS

On July 28, 2011, SunLink announced the private placement of approximately 1,338,000 common shares at $1.90 per share with certain of its officers and directors and/or their affiliates. The net proceeds of the private placement of approximately $2,500 were used, together with the Company s operating funds, to make an $8,000 pre-payment on the Credit Facility Term Loan. Concurrent with and conditioned upon the Term Loan pre-payment, the Company s lenders modified the Credit Facility to reduce the interest rate, revise certain financial and other covenants and extend the maturity date of the Credit Facility until January 1, 2013. See Note 10 Long-Term Debt. A special committee of the Company s Board of Directors comprised of disinterested directors evaluated the private placement transaction and obtained an opinion of an outside advisor selected by the special committee that the price and terms of the private placement were fair from a financial point of view to the Company.

The Company s Board of Directors authorized the private placement before August 31, 2011 of a total of up to 3,800,000 of the Company s common shares at a price equal to the average closing price for the prior ten trading days (on which the Company s shares traded) with a minimum placement of $2,500.

On March 8, 2012, the Company and its HealthMont of Georgia, Inc. subsidiary entered into an Asset Purchase Agreement by and among HealthMont of Georgia, Inc., SunLink and Hospital Authority of Tift County, Georgia (Buyer) effective March 1, 2012 to sell substantially all of the assets of the Company s owned Memorial Hospital of Adel and Memorial Convalescent Center (Adel) to the Buyer for approximately $8,300. Effective April 1, 2012 that Buyer began management of Adel pursuant to the terms of a management agreement from such date until closing. The transaction is subject to a number of conditions, including buyer due diligence and lender approvals, and is expected to close in SunLink s first fiscal quarter of 2013. (See Note 5. Discontinued Operations.)

On March 26, 2012, SunLink Health Systems, Inc., HealthMont of Missouri, LLC (Borrower), HealthMont LLC (HLLC) entered into and closed on a $5,000 Loan Agreement with a bank dated as of March 16, 2012 (the Callaway RDA Loan). The loan is guaranteed by the Company and HLLC. HealthMont of Missouri, LLC owns and operates Callaway Community Hospital (Callaway) in Fulton, Missouri. The Loan Agreement consists of two promissory notes; a $4,000 note and $1,000 note. The $4,000 was drawn in its entirety on March 26, 2012. The $1,000 will be drawn upon commencement of construction and improvement projects.

5. DISCONTINUED OPERATIONS

All of the businesses discussed below are reported as discontinued operations and the consolidated financial statements for all prior periods have been adjusted to reflect this presentation.

Memorial Hospital of Adel On March 8, 2012, the Company and its HealthMont of Georgia, Inc. subsidiary entered into an Asset Purchase Agreement by and among HealthMont of Georgia, Inc., SunLink and Hospital Authority of Tift County, Georgia (Buyer) effective March 1, 2012 to sell substantially all of the assets of the Company s owned Memorial Hospital of Adel and Memorial Convalescent Center (Adel) to the Buyer for approximately $8,300. Excluded assets include accounts receivable as of the Cutoff Date and all Medicare and Medicaid incentive payments for meaningful use of electronic health record technology and all receivables, claims and settlements made pursuant to the Indigent Care Trust Fund of the State of Georgia, in each case, paid with respect to the fiscal year ending June 30, 2012. Retained liabilities generally consist of liabilities incurred prior to the closing date of the transaction. Effective April 1, 2012, Buyer began management of Adel under a management agreement to continue from such date until the scheduled date of closing. Pursuant to the terms of the management agreement, the

Buyer is to retain any profit earned and fund any losses incurred during the management period. The transaction is subject to a number of conditions and is expected to close in SunLink s first fiscal quarter of 2013. The agreement may be terminated by either SunLink or the Buyer if the transaction is not consummated prior to July 31, 2012 or such later date as the parties may agree. Subject to certain conditions, if the Buyer terminates the agreement during the period April 1, 2012 through July 31, 2012 from other than a default by the Company, SunLink will be entitled to a breakup fee of $900. SunLink anticipates that the sale of assets of Adel for approximately $8,300, less estimated sale expenses, will result in net proceeds of approximately $7,500 to the Company and that the Company will be required to use all or substantially all of the net proceeds to pay down senior debt under the Company s Credit Facility.

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Adel s operations have been reclassified as discontinued operations in our consolidated financial statements as of and for the fiscal year ended June 30, 2011, 2010 and 2009.

Chilton Medical Center On March 1, 2011, SunLink entered into an agreement to lease its owned Chilton Medical Center (Chilton) and to sell its 83% membership interest in Clanton Hospital LLC (Clanton) subsidiary, which manages Chilton, to Carraway Medical Systems, Inc. (Carraway). The lease agreement is for a six-year term with monthly rent of $37 and includes an option under which Carraway can purchase Chilton from SunLink. The option purchase price is $3,700, less the amount paid to purchase the 17% membership interest of Clanton that Carraway does not currently own, up to a maximum of $615. The purchase price of SunLink s 83% membership interest in Clanton was a $1,000 six-year zero-coupon note plus a six-year 6% note for the net working capital of Clanton at purchase. If the purchase option for Chilton is exercised during the six-year term of the lease, any amount paid under the $1,000 note will be credited to the option purchase price and any remaining balance on the note will be cancelled. As a result, the note at June 30, 2011 was recorded on the balance sheet at net $0. Pursuant to the terms of the sale and lease and agreement, SunLink is entitled to receive 75% of the Electronic Health Records Medicare incentive reimbursement received by Clanton.

Housewares Segment All claims in a liquidation proceeding with respect to SunLink s former Housewares segment were settled on April 13, 2010. In connection with the settlement of such claim SunLink paid approximately $1,400, of which $480 was covered under a directors and officers insurance policy. The Company cancelled all preferred stock of its SunLink subsidiary held by the former Housewares segment subsidiary. The pre-tax loss of $464 for the fiscal year ended June 30, 2010 resulted from legal expenses incurred.

Mountainside Medical Center On June 1, 2004, SunLink sold its Mountainside Medical Center (Mountainside) hospital in Jasper, Georgia, for approximately $40,000 pursuant to the terms of an asset sale agreement. In connection with this sale, claims by the buyer and counter claims by SunLink were litigated which resulted in a judgment for SunLink. The judgment, which included damages, prejudgment interest and certain losses, was collected by SunLink in the amount of $1,246 in May 2010 and $540 in December 2010, and the parties executed a mutual release. Included in the pre-tax earnings of Mountainside for the fiscal year ended June 30, 2011 is the judgment of $540 related to the litigation with the buyer claim and SunLink s counterclaim. Also included in pre-tax earnings for the fiscal year ended June 30, 2011 were legal expenses of $194 related to the litigation with the buyer claim and SunLink s counterclaim. Included in the pre-tax earnings of Mountainside for the fiscal year ended June 30, 2010 is the judgment of $1,829, composed of a total of a $1,560 payment plus $266 of accrued judgment interest. Also included in pre-tax earnings for the fiscal year ended June 30, 2010 were legal expenses related to the litigation with the buyer claim and SunLink s counterclaim.

Life Sciences and Engineering Segment SunLink retained a defined benefit retirement plan which covered substantially all of the employees of this segment when the segment was sold in fiscal 1998. Effective February 28, 1997, the plan was amended to freeze participant benefits and close the plan to new participants. Pension expense and related tax benefit or expense is reflected in the results of operations for this segment for the fiscal years ended June 30, 2011, 2010 and 2009.

Industrial Segment In fiscal 1989, SunLink discontinued the operations of its industrial segment and subsequently disposed of substantially all related net assets. However, potential obligations remained relating to product liability claims for products sold prior to disposal. In the fiscal year ended June 30, 2009, the loss reserve of $161 for such claims was reversed by SunLink as it was determined no loss reserve was needed.

Discontinued Operations Reserves Over the past 22 years SunLink has discontinued operations carried on by its former Chilton Medical Center, Mountainside Medical Center and its former industrial, U.K. leisure marine, life sciences and engineering, and European child safety segments, as well as the U.K. housewares segment. SunLink s reserves related to discontinued operations of these segments represent management s best estimate of SunLink s possible liability for property, product liability and other claims for which SunLink may incur liability. With the settlement of litigation related to the Housewares Segment and Mountainside during fiscal year 2010, no reserve for discontinued operations is included in the June 30, 2011 and 2010 balance sheets.

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The following is a summary of the loss reserves for discontinued operations:

	Years Ended June 30,		
	2011	2010	2009
Beginning balance	$	$ 643	$ 1,326
Usage		(643)	(443)
Exchange differences			(240)
	$	$	$ 643

Results of discontinued operations were as follows:

Discontinued Operations Summary Statement of Earnings Information

	Years Ended June 30,		
	2011	2010	2009
Net Revenues:			
Memorial Hospital of Adel	$ 17,856	$ 16,844	$ 18,600
Chilton Medical Center	9,447	14,615	16,943
	$ 27,303	$ 31,459	$ 35,543
Earnings (loss) from discontinued operations:			
Memorial Hospital of Adel			
Earnings (loss) from operations	$ (782)	$ (603)	$ 311
Income tax expense (benefit)	(258)	(167)	117
Earnings (loss) from Memorial Hospital of Adel after taxes	(524)	(436)	194
Chilton Medical Center			
Earnings (loss) from operations	$ (724)	$ (134)	$ 525
Gain on sale	438		
Income tax expense (benefit)	50	(62)	263
Earnings (loss) from Chilton Medical Center after taxes	(336)	(72)	262
Housewares Segment:			
Loss from operations		(464)	(241)
Income tax benefit		(64)	(106)
Loss from Housewares Segment after taxes		(400)	(135)
Mountainside Medical Center			
Earnings (loss) from operations	347	1,731	(139)
Income tax expense (benefit)	119	238	(62)
Earnings (loss) from Mountainside Medical Center after taxes	228	1,493	(77)

Life sciences and engineering segment:			
Loss from operations	(83)	(71)	(58)
Income tax benefit	(28)	(10)	(25)
Loss from life sciences and engineering segment after taxes	(55)	(61)	(33)
Industrial segment:			
Earnings from operations			161
Income tax expense			71
Earnings from industrial segment after taxes			90
Earnings (loss) from discontinued operations	$ (687)	$ 524	$ 301

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6. NET RECEIVABLES

SunLink has agreements with third-party payors that provide for payments at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per Diagnosis Related Group. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient nonacute services, certain outpatient services, and defined capital and medical education costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. Cost reimbursable items are paid at a tentative rate, with final settlement determined after submission of annual cost reports and audits thereof by the Medicare fiscal intermediary.

Medicaid Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed either under contracted rates or reimbursed for cost reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports and audits thereof by the Medicaid fiscal intermediary.

SunLink also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Summary information for receivables is as follows:

	June 30,	
	2011	**2010**
Patient accounts receivable (net of contractual allowance)	$ 28,619	$ 30,761
Less allowance for doubtful accounts	(12,317)	(14,725)
Patient accounts receivable (net of allowances)	$ 16,302	$ 16,036

Net revenues included $709, $1,201, and $394, for the years ended June 30, 2011, 2010 and 2009, respectively, for the settlements and filings of prior year Medicare and Medicaid cost reports.

7. MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVES
DEFERRED GAIN MEDICARE ELECTRONIC HEALTH RECORDS INCENTIVES

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 the American Recovery and Reinvestment Act of 2009 (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 and critical access hospitals (CAH) 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 ASC 450-30. In accordance with ASC 450-30, the Company recognizes EHR incentive payments when all contingencies relating to the incentive payment have been satisfied and compliance with the EHR meaningful use criteria have been attested to. For recognition of Medicaid EHR incentive payments, recognition of the payments will be at the time of attestation to EHR meaningful use criteria since Medicaid payments for the states in which the Company operates are based upon historical cost report information with no subsequent payment adjustment. However, for Medicare EHR incentive payments, recognition is being deferred until both the Medicare federal fiscal year during which EHR meaningful use was demonstrated ends and the cost report information utilized to determine the final amount of reimbursement is known. 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 Centers for Medicare and Medicaid Services.

SunLink s five operating hospitals and Adel and Chilton (see Note 5. Discontinued Operations) successfully attested for the Medicare EHR program for the fiscal year ended June 30, 2011. Incentive payments for all five operating hospital and Adel and Chilton totaling $8,521 were received by SunLink during the quarter ended June 30, 2011. As Medicare EHR incentive

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payments cannot be recognized until the cost report information utilized to determine the final amount of reimbursement is known, SunLink has recorded the $8,521 (Restated See Note 1) of deferred gain as of June 30, 2011 This deferred gain is expected to be recognized in the quarter ended June 30, 2012, when information for the cost report period July 1, 2011 through June 30, 2012 is known. SunLink s hospital in Mississippi successfully attested for the Medicaid EHR program and recognized the Medicaid EHR incentive reimbursement in the quarter ended June 30, 2011 in the amount of $277.

8. INVENTORY

Consisted of the following:

	June 30, 2011	June 30, 2010
Healthcare Facilities Segment Supplies Inventory	$ 2,121	$ 2,070
Specialty Pharamcy Segment Goods Held for Sale	2,250	2,136
	$ 4,371	$ 4,206

9. GOODWILL AND INTANGIBLE ASSETS

SunLink has goodwill related to its Healthmont and Carmichael acquisitions. We have intangible assets related to these acquisitions, as well. We also have intangible assets related to three Healthcare Facilities Segment clinic purchases.

Goodwill consists of the following:

	June 30, 2011	June 30, 2010
Healthcare Facilities Segment	$ 931	$ 931
Specialty Pharamcy Segment	461	6,509
	$ 1,392	$ 7,440

Intangible assets consist of the following, net of amortization:

	June 30, 2011	June 30, 2010
Healthcare Facilities Segment		
Certificates of Need	$ 80	$ 80
Noncompetition Agreements	83	83
	163	163
Accumulated Amortization	(91)	(61)
	72	102
Specialty Pharmacy Segment		

Trade Name	2,000	5,400
Customer Relationships	1,089	6,400
Medicare License	769	769
	3,858	12,569
Accumulated Amortization	(453)	(1,280)
	3,405	11,289
Total	$ 3,477	$ 11,391

The trade name intangible asset under the Specialty Pharmacy Segment is a non-amortizing intangible asset.

Amortization expense was $171, $787, and $883, for the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

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Annual amortization of amortizing intangibles for the next five years and thereafter is as follows:

2012	$ 158
2013	145
2014	145
2015	145
2016	145
2017 and thereafter	739
Total	$ 1,477

Impairment testing During the fourth quarter of fiscal 2011, we completed our annual impairment testing of goodwill and certain intangible assets. The analysis resulted in a goodwill impairment charge of $6,048 related to the Specialty Pharmacy Segment for fiscal 2011. Additionally, the Company recognized a $3,400 impairment charge to trade name and a $3,899 impairment charge to customer relationships for the fiscal year ended June 30, 2011 for the Specialty Pharmacy Segment. The decline in fair value of our Specialty Pharmacy Segment below its book value was is primarily the result of lower than expected revenue and customer growth relative to the assumptions made at the acquisition date.

The following table summarized goodwill and intangible asset impairment charges for the fiscal year ended June 30, 2011:

	June 30, 2011
Specialty Pharmacy Segment	
Goodwill	$ 6,048
Intangible assets	
Trade Name	3,400
Customer Relationships	3,899
Total	$ 13,347

10. LONG-TERM DEBT

Long-term debt consisted of the following:

	June 30,	
	2011	2010
Term Loan	$ 29,086	$ 30,836
Capital lease obligations	169	51
Total	29,255	30,887
Less current maturities	(1,814)	(1,797)
	$ 27,441	$ 29,090

SunLink Credit Facility On April 23, 2008, SunLink entered into a $47,000 seven-year senior secured credit facility (Credit Facility) comprised of a revolving line of credit of up to $12,000 (the Revolving Loan) and a $35,000 term loan (the Term Loan). The Credit Facility has subsequently been amended by three modification agreements, on September 27, 2010 (September 2010 Modification), March 1, 2011 (March

2011 Modification) and July 28, 2011 (July 2011 Modification). The Revolving Loan commitment was reduced to $9,000 by the September 2010 Modification. At June 30, 2011, the Revolving Loan balance was $5,300 with an interest rate at LIBOR plus 10.5% (13.25% at June 30, 2011) and the Term Loan had an outstanding balance of $29,086 with an interest rate at LIBOR plus 12.07% (14.82% at June 30, 2011). In the Credit Facility, LIBOR is defined as the Thirty-Day published rate, not to be less than 2.75%, nor more than 5.50%. The maximum availability of the Revolving Loan is keyed to the calculated net collectible value of eligible accounts receivable. Under the terms of the July 2011 Modification, SunLink made an $8,000 prepayment of the Term Loan and paid a modification fee of $131. The source of the repayment was $2,500 of proceeds from a private placement of SunLink common shares primarily to directors and affiliates and $5,500 of operating funds. Under the July 2011 Modification, the interest rate under the Revolving Loan was adjusted to LIBOR plus 8.875%, or 11.625% at July 28, 2011 and the interest rate under the Term Loan was adjusted to LIBOR plus 10.82%, or 13.57% at July 28, 2011. The termination date of the Credit Facility was changed to January 1, 2013. The termination date had been changed to September 30, 2011 in the September 2010 modification. Financing costs and expenses related to the Credit Facility of $2,522 are being amortized over the modified life of the Facility. Accumulated amortization and amortization expense was approximately $2,322 and $1,485, respectively, as of and for the fiscal year ended June 30, 2011 and $438 and $378 as of and for the fiscal year ended June 30, 2010. The increased financing cost amortization in the fiscal year ended June 30, 2011 resulted from the change in the termination date of the Credit Facility from April

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2015 to September 2011 in the September 2010 modification. The Credit Facility is secured by a first priority security interest in substantially all real and personal property of the Company and its consolidated domestic subsidiaries, including a pledge of all of the equity interests in such subsidiaries.

The Credit Facility contains various terms and conditions, including operational and financial restrictions and limitations, and affirmative and negative covenants. The covenants include financial covenants measured on a quarterly basis which require SunLink to comply with maximum leverage and minimum fixed charge ratios, maximum capital expenditure amounts, collateral value to loan amount and liquidity and cash flow measures, all as defined in the Credit Facility. Although SunLink was not in compliance with certain of the financial covenants contained in the Credit Facility at June 30, 2011, the Credit Facility was subsequently amended by the July Modification to change the affected covenants so as to bring us into compliance. We believe that the Company should be able to continue in compliance with the revised levels of financial covenants and terms in the Credit Facility during the fiscal year ending June 30, 2012, but there is no assurance that the Company will be able to do so.

In the September 2010 Modification, the termination date of the Credit Facility was changed from April 22, 2015 to September 30, 2011 and it contained conditions for waivers of the non-compliance with financial covenants for the quarters ended September 30, 2010, December 31, 2011 and March 31, 2011. The September 2010 and March 2011 Modifications also included increases to the interest rate for the Revolving Loan to LIBOR plus 6.50% from the waiver date through November 14, 2010, LIBOR plus 7.50% from November 15, 2010 to February 15, 2011, LIBOR plus 8.50% from February 16, 2011 to April 14, 2011, LIBOR plus 9.50% from April 15, 2011 to May 15, 2011, LIBOR plus 10.50% from May 16, 2011 to July 15, 2011 and LIBOR plus 11.50% from July 16, 2011 through the July 28, 2011 closing date of the July 2011 Modification. They also increased the interest rate for the Term Loan to LIBOR plus 8.07% from the September 2010 Modification date through November 14, 2010, LIBOR plus 9.07% from November 15, 2010 to February 15, 2011, LIBOR plus 10.07% from February 16, 2011 to April 15, 2011, LIBOR plus 11.07% from April 15, 2011 to May 15, 2011, LIBOR plus 12.07% from May 16, 2011 to July 15, 2011 and LIBOR plus 13.07% from July 16, 2011 through the July 28, 2011 closing date of the July 2011 Modification. Under the July 2011 Modification, the interest rate under the Revolving Loan was adjusted to LIBOR plus 8.875%, or 11.625% at July 28, 2011 and the interest rate under the Term Loan was adjusted to LIBOR plus 10.82%, or 13.57%, at July 28, 2011. A waiver fee of 2% of the current Credit Facility commitment totaling approximately $788 was due at the September 2011 Modification closing and additional waiver fees of 0.5% of the total Credit Facility commitment were paid at November 15, 2010, February 15, 2011 and May 15, 2011. The July 28, 2011 Modification includes conditions related to a September 2011 and December 2011 Term Loan Reduction Covenant which may increase the interest rate for both the Term Loan and the Revolving Loan by an additional 0.5% over the prescribed interest rate for the remainder of the agreement. If the Term Loan Reduction Covenants are met, the interest rate for both the Term Loan and the Revolving Loan may decrease by an additional 1.25% over the prescribed interest rate for the remainder of the agreement. If we fail to remain in compliance with the Credit Facility as modified, we would cease to have a right to draw on the revolving line of credit facility and the lenders would, among other things, be entitled to call a default and demand repayment of the indebtedness outstanding. If SunLink or its applicable subsidiaries experience a material adverse change in their business, assets, financial condition, management or operations, or if the value of the collateral securing the Credit Facility decreases, we may be unable to draw on the credit facility.

Annual required payments of debt for the next two years are as follows:

2012	$ 1,814
2013	27,409
2014	32
Total	$ 29,255

The contractual commitments for interest on long-term debt are shown in the following table. The interest rate on variable interest debt is calculated at the interest rate at June 30, 2011 per the July 2011 Modification.

2012	$ 3,079
2013	1,343
2014	1

Total	$ 4,423

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11. SUBORDINATED LONG-TERM DEBT

Subordinated long-term debt consisted of the following:

	June 30, 2011	June 30, 2010
Carmichael	$ 2,497	$ 2,550
Less current maturities	(300)	(300)
	$ 2,197	$ 2,250

Carmichael Note On April 22, 2008, SunLink Scripts Rx, LLC entered into a $3,000 promissory note agreement with an interest rate of 8% (Carmichael Note) with the former owners of Carmichael as part of the acquisition purchase price. The note is payable in semi-annual installments of $150 beginning on April 22, 2009 with the remaining balance of $1,200 due April 22, 2015. Interest is payable in arrears semi-annually on the six-month anniversary of the issuance of the note. The note is guaranteed by SunLink Health Systems, Inc. for the payment of principal and accrued interest. The note is subordinate to the Credit Facility.

Under the terms of the Credit Facility (see Note 8), if SunLink is in violation of certain terms and conditions of this Facility, the Company cannot make principal payments of the Carmichael Loan without permission of the Credit Facility lender.

On April 12, 2011, an amendment to the Carmichael Note (Carmichael Note Amendment) was entered into under which SunLink has the option to issue subordinated promissory notes to the former owners of Carmichael in payment of up to two semi-annual payments of principal and interest due under the Carmichael Note. The notes will bear an interest rate of 8% and will be due on April 22, 2015. A note of $247 was issued on April 22, 2011 for the principal and interest payment that would have been due on April 22, 2011.

Annual required payments of debt for the next five years and thereafter are as follows:

2012	$ 300
2013	300
2014	300
2015	1,597
Total	$ 2,497

The contractual commitments for interest on the subordinated long-term debt are shown in the following table:

2012	$ 188
2013	164
2014	140
2015	64
Total	$ 556

12. SHAREHOLDERS EQUITY

Employee and Directors Stock Option Plans On November 7, 2005, the 2005 Equity Incentive Plan was approved by SunLink s shareholders at the Annual Meeting of Shareholders. This Plan permits the grant of options to employees, non-employee directors and service providers of SunLink for the purchase of up to 800,000 common shares plus the number of unused shares under the 2001 Plans, which is 30,675, by November 2015. This Plan restricts the number of Incentive Stock Options to 700,000 shares and Restricted Stock Awards to 200,000 shares. The combination of Incentive Stock Options and Restricted Stock Awards cannot exceed 800,000 shares plus the number of unused shares under the 2001 Plans. Each award of Restricted Shares reduces the number of share options to be granted by four option shares for each Restricted Share awarded. No options have been exercised under this Plan. Options outstanding under this Plan were 115,999, 272,999 and 275,999 at June 30, 2011, 2010 and 2009, respectively.

On August 20, 2001, the 2001 Outside Directors Stock Ownership and Stock Option Plan was approved by SunLink s shareholders at the Annual Meeting of Shareholders. This Plan permitted the grant of options to outside directors of SunLink for the

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purchase of up to 90,000 common shares through March 2006. Options for 90,000 shares were granted by March 2006. Options for 7,500 shares have been exercised under this plan. Options outstanding under this Plan were 45,000 at June 30, 2011 and 82,500 at June 30, 2010 and 2009, respectively. No additional awards may be granted under this Plan.

On February 28, 2001, the 2001 Long-Term Stock Option Plan was approved by the Board of Directors of SunLink. The 2001 Long-Term Stock Option Plan permitted the grant of options to officers and other key employees for the purchase of up to 810,000 common shares through February 2006. Options totaling 299,734 shares under this plan have been exercised. Options outstanding under this Plan were 13,250, 38,125, and 77,300 at June 30, 2011, 2010 and 2009, respectively. No additional awards may be granted under this Plan.

SunLink s 1995 Incentive Stock Option Plan permitted the grant of options to officers and key employees to purchase up to 250,000 common shares through May 2005. Vesting and option expiration periods for options granted were determined by the Board of Directors but could not exceed 10 years. Options for 246,000 shares have been exercised and no options for shares were outstanding at June 30, 2011. 4,000 options for shares were outstanding at June 30, 2009. No additional awards may be granted under this Plan.

The activity of Company s share options is shown in the following table:

	Number of Shares	Weighted-Average Exercise Price	Range of Exercise Prices
Options outstanding July 1, 2008	1,190,980	$ 6.20	$1.50 - $10.24
Granted	28,000	2.51	2.51
Exercised	(118,450)	1.56	1.05 - 3.00
Forfeited	(660,731)	7.74	1.50 - 10.24
Options outstanding June 30, 2009	439,799	6.20	1.50 - 10.24
Granted			
Exercised	(29,050)	1.72	1.50 - 2.50
Forfeited	(17,125)	3.41	2.51 - 5.48
Options outstanding June 30, 2010	393,624	5.19	1.50 - 10.24
Granted			
Exercised	(40,500)	1.59	2.65 - 1.50
Forfeited	(178,875)	5.41	2.50 - 5.86
Options outstanding June 30, 2011	174,249	$ 5.80	$2.50 - $9.63
Options exercisable June 30, 2009	353,799	$ 4.95	$1.50 - $10.24
Options exercisable June 30, 2010	348,285	$ 5.26	$1.50 - $9.63
Options exercisable June 30, 2011	168,909	$ 5.91	$2.50 - $9.63

The weighted-average fair value of each option granted during the year ended June 30, 2009 was $2.51. The fair value of each stock option grant was estimated using the Black-Scholes option pricing model with the following weighted-average assumptions used for grants during the year ended June 30, 2009: estimated volatility of 57%; risk-free interest rate of 2.75%; dividend yield of 0%; and an expected life of 6 years. The historical volatility is used to calculate the estimated volatility. The expected lives of the stock option grant was determined to be the midpoint between the vesting period and the contractual term of the grants. The estimate of the forfeited options in the compensation expense calculation was determined as the weighted-average forfeitures for the last three years. For the years ended June 30, 2011, 2010 and 2009, the Company recognized $6, $40 and $190, respectively, of compensation expense for share options issued. As of June 30, 2011, there was $4 of unrecognized compensation cost related to nonvested share-based compensation arrangements granted under the Plans. That cost is expected to be recognized during the fiscal year ended June 30, 2012.

In November 2008, SunLink approved an Executive Bonus Plan for 2009 (the Bonus Plan), which is a variable cash incentive program designed to reward executives of SunLink and its affiliates for successful achievement of certain short-term corporate goals and objectives. The Bonus Plan was offered to all of the Company s executive officers and certain other employees. In order to participate in the Bonus Plan, each participant agreed to relinquish any and all stock options that such participant held that had an exercise price equal to or greater than $6.00 per share. During the fiscal year ended June 30, 2009, stock options totaling 601,106 shares were relinquished under the Plan.

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Information with respect to stock options outstanding and exercisable at June 30, 2011 is as follows:

Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (in years)	Number Exercisable
$ 2.50	6,250	0.99	6,250
$ 2.51	16,000	7.23	10,660
$ 2.65	6,000	0.69	6,000
$ 2.90	37,500	2.45	37,500
$ 2.91	7,500	0.15	7,500
$ 3.00	1,000	0.15	1,000
$ 6.55	33,000	5.88	33,000
$ 8.00	33,999	6.24	33,999
$ 9.63	33,000	4.37	33,000
	174,249	4.41	168,909

The total intrinsic value of options exercised during the years ended June 30, 2011, 2010 and 2009 were $1, $16, and $72, respectively. As of June 30, 2011, the aggregate intrinsic value of options outstanding and options exercisable were $0 and $0, respectively. As of June 30, 2010, the aggregate intrinsic value of options outstanding and options exercisable were $29 and $29, respectively.

Shareholder Rights Plan On February 8, 2004, the Board of Directors of the Company declared a dividend of one Series A Voting Preferred Purchase Price Right (a Right) for each outstanding common share of the Company to record owners of common shares at the close of business on February 10, 2004. Shares issued subsequent to such date are issued with a Right. The Board of Directors declared these Rights to protect shareholders from coercive or otherwise unfair takeover tactics. The Rights should not interfere with any merger or other business combinations approved by the Board of Directors. The Rights expire on February 8, 2014 unless the Company redeems them at an earlier date. The Company may redeem the Rights in whole, but not in part, at a price of $0.001 per Right, at any time prior to a public announcement that a person has become an Acquiring Person.

Accumulated Other Comprehensive Income (Loss) Information with respect to the balances of each classification within accumulated other comprehensive income (loss) is as follows:

	Foreign Currency Translation Adjustment	Minimum Pension Liability Adjustment	Accumulated Other Comprehensive Income (Loss)
June 30, 2008	$ (327)	$ (256)	$ (583)
Current period change	281	(35)	246
June 30, 2009	(46)	(291)	(337)
Current period change	46	(10)	36
June 30, 2010		(301)	(301)
Current period change		23	23
June 30, 2011	$	$ (278)	$ (278)

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13. INCOME TAXES

The provision (benefit) for income taxes on continuing operations are as follows:

	Year ended June 30,		
	2011 (Restated See Note 1)	2010	2009
Domestic:			
Current	$ (834)	$ 917	$ 2,124
Deferred	(7,775)	(1,495)	(1,428)
Total income tax (benefit) expense	$ (8,609)	$ (578)	$ 696

Net deferred tax assets recorded in the balance sheets are as follows:

	June 30,	
	2011 (Restated See Note 1)	2010
Net operating loss carryforward	$ 3,004	$ 2,541
Depreciation expense	(3,954)	(3,671)
Allowances for receivables	3,727	4,588
EHR Deferred gain	3,260	0
Accrued expenses	2,904	2,455
Intangible assets	4,879	(321)
Pension liabilities	42	25
Other	(152)	138
	13,710	5,755
Less valuation allowance	(2,078)	(1,350)

The differences between income taxes at the Federal statutory rate and the effective tax rate were as follows:

	Year ended June 30,		
	(Restated See Note 1) 2011	2010	2009
Income tax at Federal statutory rate	$ (8,212)	$ (391)	$ 491
Changes in valuation allowance continuing operations	588	(86)	(78)
U.S. state income taxes, net of federal benefit	(1,046)	(319)	211
Share option expense	2	13	69
Other	59	205	120
Total income tax expense (benefit) continuing operations	$ (8,609)	$ (578)	$ 813

The Company provided a $2,078 deferred tax valuation allowance as of June 30, 2011 so that the net deferred tax assets were $11,632 (Restated See Note 1) as of June 30, 2011. Based upon management s assessment, the Company determined that it was more likely than not that a

portion of its deferred tax asset would not be recovered. The increase in the valuation allowance during the fiscal year ending June 30, 2011 resulted from reserving for certain state net operating loss carryforwards that were not reserved for in prior periods. It is more likely than not that these net operating loss carryforwards will not be realized in future years. The Company provided a $1,350 deferred tax valuation allowance as of June 30, 2010 so that the net deferred tax assets were $4,405 as June 30, 2010. The net operating loss carryforwards expire in 2023.

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The Company accounts for uncertainty in income taxes for a change in judgment related to prior years tax positions in the quarter of such change. Activity in the unrecognized tax benefit liability account is as follows from July 1, 2008 through June 30, 2011:

Balance at July 1, 2008	$ 58
Additions based on tax positions related to current year	31
Additions for tax positions of prior years	
Reductions for tax positions of prior years	(23)
Settlements	
Balance at July 1, 2009	66
Additions based on tax positions related to current year	35
Additions for tax positions of prior years	
Reductions for tax positions of prior years	(30)
Settlements	
Balance at June 30, 2010	71
Additions based on tax positions related to current year	
Additions for tax positions of prior years	
Reductions for tax positions of prior years	(34)
Settlements	
Balance at June 30, 2011	$ 37

14. NONCONTROLLING INTEREST

On July 1, 2009, SunLink sold 49% of its Specialty Pharmacy operations subsidiary in Ellijay, Georgia, to an unaffiliated buyer at a sales price $76. In December 2007, the FASB issued new guidance relating to accounting for noncontrolling interests in consolidated financial statements and requires that noncontrolling interests in subsidiaries be reported in the equity section of the controlling company s balance sheet. The Company adopted this guidance on July 1, 2009.

15. EMPLOYEE BENEFITS

Defined Benefit Plans No defined benefit plan is maintained for employees of either the Healthcare Facilities Segment or the Specialty Pharmacy Segment. Prior to SunLink s acquisition of its initial hospitals, it historically maintained defined benefit retirement plans covering substantially all of its employees. Effective February 28, 1997, SunLink amended its domestic retirement plan to freeze participant benefits and close the plan to new participants. Benefits under the frozen plan are based on years of service and level of earnings. SunLink funds the frozen plan, which is noncontributory, at a rate that meets or exceeds the minimum amounts required by the Employee Retirement Income Security Act of 1974.

With the sale of SunLink s life sciences and engineering segment businesses in the fiscal year ended March 31, 1999, net pension expense is now classified as an expense of discontinued operations. During the years ended June 30, 2011 and 2010, SunLink recognized curtailment losses of $0 and $0, respectively, for partial plan settlement of pension obligations to vested former employees.

At June 30, 2011, the plan s assets are invested 76% in cash and short term investments, 13% in equity investments and 11% in fixed income investments. The plan s current investment policy of primarily investing in cash and short term investments is in response to the poor returns on investment of the past 5 years in the equity markets, the returns available in the fixed income markets and the possible need for immediate liquidity as participants retire or withdraw from the plan. The expected return on investment of 4.0% is based upon the plan s historical return on assets. The plan expects to pay $55, $63, $60, $66, and $71 in pension benefits in the years ending June 30, 2012 though 2016, respectively. The plan expects to pay $372 in pension benefits for the years June 30, 2017 through 2021, in the aggregate. This assumes the plan participants elect to take monthly pension benefits as opposed to a lump sum payout when they reach age 65. The Company made no contributions to the plan for the year ended June 30, 2011.

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The components of net pension expense for all plans (comprised solely of a domestic plan), excluding the curtailment losses above, were as follows:

	Years Ended June 30,		
	2011	2010	2009
Service cost	$	$	$
Interest cost	74	72	71
Expected return on assets	(41)	(45)	(49)
Amortization of prior service cost	55	44	36
Net pension expense	$ 88	$ 71	$ 58
Weighted average assumptions:			
Discount rate	6.50%	6.50%	6.50%
Expected return on plan assets	4.00%	4.00%	4.00%
Rate of compensation increase	0.00%	0.00%	0.00%

Summary information for the plans (comprised solely of a domestic plan) is as follows:

	2011	2010
Change in Benefit Obligation		
Benefit obligation at beginning of year	$ 1,159	$ 1,136
Interest cost	74	72
Actuarial (gain) loss	(13)	16
Benefits paid	(63)	(65)
Benefit obligation at end of year	$ 1,157	$ 1,159
Change in Plan Assets		
Fair value of plan asset at beginning of year	$ 1,093	$ 1,157
Actual return on plan assets	15	1
Benefits paid	(63)	(65)
Fair value of plan asset at end of year	$ 1,045	$ 1,093
Funded status of the plans	(111)	(65)
Unrecognized actuarial loss	446	484
Prepaid benefit cost	$ 335	$ 419
Amounts Recognized in Consolidated Balance Sheets		
Prepaid benefit cost	(111)	(65)
Accumulated other comprehensive income*	446	484
Net amount recognized	$ 335	$ 419

* Accumulated other comprehensive income represents pretax minimum pension liability adjustments.

Defined Contribution Plan SunLink has a defined contribution plan pursuant to IRS Section 401(k) covering substantially all domestic employees. SunLink matches a specified percentage of the employee s contribution as determined periodically by its management. No match was provided for the fiscal years ended June 30, 2011 and 2010. Plan expenses for the defined contribution plan were $0, $0, and $66, for the years ended June 30, 2011, 2010 and 2009, respectively.

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16. COMMITMENTS AND CONTINGENCIES

Leases The Company leases various land, buildings, and equipment under operating lease obligations having noncancelable terms ranging from one to 14 years. Rent expense was $2,903, $2,691, and $2,593, for the years ended June 30, 2011, 2010 and 2009, respectively. Minimum lease commitments as of June 30, 2011 are as follows:

Fiscal year ending June 30:	
2012	$ 2,573
2013	1,134
2014	668
2015	514
2016 and thereafter	1,070
	$ 5,959

Lease Guarantee Obligation In the 2004 Healthmont acquisition, SunLink assumed a lease guarantee obligation of $500 for a facility the Company did not occupy. During the fiscal year ended June 30, 2009, we learned that the guarantee had been extinguished through an agreement between the leasor and the current leasee of the property. As a result, SunLink reversed the recorded liability for the guarantee of $500.

Physician Guarantees At June 30, 2011, SunLink had guarantee agreements with three physicians. A physician with whom a guarantee agreement is made generally agrees to maintain his or her practice within a hospital geographic area for a specific period (normally three years) or be liable to repay all or a portion of the guarantee received. The physician s liability for any guarantee repayment due to non-compliance with the provisions of a guarantee agreement generally is collateralized by the physician s patient accounts receivable and/or a promissory note from the physician. All potential payments payable under the three guarantees have been paid as of June 30, 2011. SunLink expensed $278, $458, and $462, for the fiscal years ended June 30, 2011, 2010 and 2009, respectively. There were no remaining non-cancelable commitments under guarantee agreements with physicians as of June 30, 2011.

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

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

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

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

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

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

17. RELATED PARTIES

A director of the Company and the Company s secretary are members of two different law firms, each of which provides services to SunLink. We have paid an aggregate of $896, $596, and $585 to these law firms in the fiscal years ended June 30, 2011, 2010 and 2009, respectively.

18. FINANCIAL INFORMATION BY SEGMENTS

Under ASC Topic No. 280, Segment Reporting, operating segments are defined as components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker, or decision-making group, in deciding how to allocate resources and in assessing performance. Our chief operating decision-making group is composed of the chief executive officer and members of senior management. Our two reportable operating segments are Healthcare Facilities and Specialty Pharmacy.

We evaluate performance of our operating segments based on revenue and operating income (loss). Segment information for the fiscal years ended June 30, 2011 and 2010 is as follows:

2011 (Restated See Note 1)	Healthcare Facilities	Specialty Pharmacy	Corporate and Other	Total
Net Revenues from external customers	$ 114,460	$ 39,920	$	$ 154,380
Operating profit (loss)	3,362	(14,463)	(5,496)	(16,597)
Depreciation and amortization	3,675	1,562	460	5,697
Assets	56,217	11,525	24,088	91,830
Expenditures for property, plant and equipment	1,006	751	794	2,552
2010				
Net Revenues from external customers	$ 123,360	$ 42,962	$	$ 166,322
Operating profit (loss)	8,395	(421)	(5,517)	2,457
Depreciation and amortization	4,040	1,636	448	6,124
Assets	60,419	25,195	12,876	98,490
Expenditures for property, plant and equipment	1,440	718	150	2,308

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19. EARNINGS PER SHARE
(Share Amounts in Thousands)

	Years Ended June 30,					
	2011 (Restated See Note 1)		2010		2009	
	Amount	Per Share Amount	Amount	Per Share Amount	Amount	Per Share Amount
Earnings (loss) from continuing operations	$ (15,416)		$ (422)		$ 611	
Basic:						
Weighted-average shares outstanding	8,094	$ (1.90)	8,052	$ (0.05)	7,975	$ 0.08
Diluted:						
Weighted-average shares outstanding	8,094	$ (1.90)	8,052	$ (0.05)	8,019	$ 0.08
Earnings (loss) from discontinued operations	$ (687)		$ 524		$ 301	
Basic:						
Weighted-average shares outstanding	8,094	$ (0.08)	8,052	$ 0.07	7,975	$ 0.04
Diluted:						
Weighted-average shares outstanding	8,094	$ (0.08)	8,052	$ 0.07	8,019	$ 0.04
Net Earnings (loss)	$ (16,103)		$ 102		$ 912	
Basic:						
Weighted-average shares outstanding	8,094	$ (1.99)	8,052	$ 0.01	7,975	$ 0.11
Diluted:						
Weighted-average shares outstanding	8,094	$ (1.99)	8,052	$ 0.01	8,019	$ 0.11
Weighted-average number of shares outstanding basic	8,094		8,052		7,975	
Effect of dilutive director, employee and guarantor options and outstanding common share warrants					44	
Weighted-average number of shares outstanding diluted	8,094		8,052		8,019	

Share options of 174, 321 and 388 for the years ended June 30, 2011, 2010 and 2009, respectively, are not included in the computation of diluted earnings per share because their effect would be antidilutive.

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20. SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)
(Share Amounts in Thousands)

The following selected quarterly data for the years ended June 30, 2011 and 2010, respectively, are unaudited.

		Fourth Quarter (Restated See Note 1)	Third Quarter (Restated See Note 1)	Second Quarter	First Quarter
NET REVENUE	Year Ended June 30, 2011	$ 34,667	$ 42,376	$ 40,541	$ 36,796
	Year Ended June 30, 2010	39,569	43,974	42,697	40,082
EARNINGS (LOSS) FROM CONTINUING OPERATIONS	Year Ended June 30, 2011	(10,708)	(568)	(2,089)	(2,051)
	Year Ended June 30, 2010	(1,292)	413	(138)	595
NET EARNINGS (LOSS)	Year Ended June 30, 2011	(11,255)	(314)	(1,766)	(2,768)
	Year Ended June 30, 2010	(1,516)	1,646	(524)	496
EARNINGS (LOSS) PER SHARE:					
Continuing operations					
Basic	Year Ended June 30, 2011	(1.32)	(0.07)	(0.26)	(0.25)
	Year Ended June 30, 2010	(0.16)	0.05	(0.02)	0.07
Diluted	Year Ended June 30, 2011	(1.32)	(0.07)	(0.26)	(0.25)
	Year Ended June 30, 2010	(0.16)	0.05	(0.02)	0.07
NET EARNINGS (LOSS):					
Basic	Year Ended June 30, 2011	(1.39)	(0.04)	(0.22)	(0.34)
	Year Ended June 30, 2010	(0.19)	0.20	(0.07)	0.06
Diluted	Year Ended June 30, 2011	(1.39)	(0.04)	(0.22)	(0.34)
	Year Ended June 30, 2010	(0.19)	0.20	(0.07)	0.06
WEIGHTED-AVERAGE COMMON SHARES OUTSTANDING:					
Basic	Year Ended June 30, 2011	8,119	8,095	8,082	8,081
	Year Ended June 30, 2010	8,058	8,057	8,050	8,050
Diluted	Year Ended June 30, 2011	8,119	8,095	8,082	8,081
	Year Ended June 30, 2010	8,058	8,069	8,050	8,070