SUNLINK HEALTH SYSTEMS INC
Form 10-K
September 26, 2014
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# UNITED STATES

# SECURITIES AND EXCHANGE COMMISSION

**WASHINGTON, D.C. 20549**

# Form 10-K

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

**For the Fiscal Year Ended June 30, 2014**

**OR**

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

**For the transition period from to**

**Commission File No. 1-12607**

# SunLink Health Systems, Inc.

**(Exact name of registrant as specified in its charter)**

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

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

**(Address of principal executive offices)**

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

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

| **Title of each Class** | **Name of each Exchange on which registered** |
|---|---|

| Common Shares without par value | NYSE Amex Equities |
|---|---|

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of the registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K Yes ¨ No x

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

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

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

At the close of business on September 26, 2014, there were 9,443,408 shares of the registrant s common shares without par value outstanding. The aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the closing price on December 31, 2013 of the registrant s common shares as reported by NYSE Amex Equities stock exchange amounted to $2,497,012.

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**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the registrant s definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Shareholders of SunLink Health Systems, Inc., scheduled to be held on November 10, 2014, have been incorporated by reference into Part III of this Report. The Proxy Statement or an amendment to this Annual Report will be filed with the Securities and Exchange Commission within 120 days after June 30, 2014.

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**Certain Cautionary Statements**

**FORWARD-LOOKING STATEMENTS**

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

*General Business Conditions*

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

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

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

demographic changes in areas where we operate;

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

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

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

*Operational Factors*

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

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

timeliness and amount of reimbursement payments received under government programs;

the ability or inability to obtain external financing for working capital included under lending agreements;

changes in interest rates under debt agreements;

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

restrictions imposed by existing or future debt agreements;

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

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

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

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changes in medical and other technology;

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

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

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

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

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

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

*Liabilities, Claims, Obligations and Other Matters*

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

potential adverse consequences of known and unknown government investigations;

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

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

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

*Regulation and Governmental Activity*

existing and proposed governmental budgetary constraints;

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

the decision by states in which we operate hospitals (Georgia, Mississippi, Missouri) to not expand Medicare;

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

anticipated adverse changes in the levels and terms of government (including Medicare, Medicaid and other programs) and private reimbursement for SunLink s healthcare services including the payment arrangements and terms of managed care agreements, EHR reimbursement and indigent care reimbursement (Medicare Upper Payment Limit UPL and Disproportionate Share Hospital DSH adjustments);

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

the possible enactment of additional Federal healthcare reform laws or reform laws in states where our subsidiaries operate hospital and pharmacy facilities (including Medicare and Medicaid waivers, bundled payments, accountable care and similar organizations, competitive bidding and other reforms).

*Dispositions, Acquisitions, and Renovation Related Matters*

the ability to dispose of underperforming facilities;

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

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

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

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

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

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**PART I**

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

**Overview**

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

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

**History**

We are an Ohio corporation incorporated in June 1959. In 2001 we redirected our business strategy toward healthcare services in the United States. On February 1, 2001, we purchased five community hospitals, leasehold rights for a sixth hospital and the related businesses of all six hospitals. We subsequently have acquired two hospitals and sold three hospitals and three home health businesses. We also sold the operations of one hospital to a buyer who leased the hospital building from us but which subsequently ceased its hospital operations. In 2008 a wholly-owned subsidiary acquired Carmichael s Cashway Pharmacy, Inc. ( Carmichael ) which provides retail and institutional pharmacy services to various communities in southwest Louisiana and eastern Texas.

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

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

*Operations Strategy*

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

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the nursing homes is similar to that for the community hospitals and is focused on expanding services and implementing and maintaining effective cost controls. Our operational strategy for our Specialty Pharmacy segment is focused on increasing market share, expanding services, and implementing and maintaining effective cost controls.

*Disposition and Acquisition Strategy*

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

Although the Company s situation could change, based on our current financial position as well as uncertainties in the healthcare industry, we are not actively seeking acquisitions for either our Healthcare Facilities Segment or our Specialty Pharmacy Segment. However, during the last fiscal year, we have evaluated certain rural healthcare businesses which were for sale and monitored other selected healthcare acquisition targets which we believed might become available for sale. Although we have no current plans to do so, from time to time we may consider the acquisition of other complementary based healthcare businesses, outside of our existing business segments, which are or may become available for acquisition.

Historically, we have targeted the rural or exurban community hospital market because we believed it provided an attractive sector for investment in healthcare facilities. We continue to believe hospitals and other healthcare businesses in our markets generally may experience (1) less direct competition although competition has increased substantially in recent years in each market, (2) lower managed care penetration, (3) more manageable inflationary pressure with respect to certain costs, (4) higher staff, employee and community loyalty, and (5), in certain cases, opportunities for future growth. On the other hand, rural and exurban community hospitals continue to experience, among other things, substantial out-migration by patients to urban medical centers, difficulties in recruiting physician and nursing staffs, low inpatient occupancy levels, and high proportion of government insured and of uninsured patients vs. privately insured patients. The focus of future acquisition activities will depend on our evaluation of relative opportunities for growth and profitability within the business segments and services lines of our existing operations, our financial position, the capital needs of our existing and potential operations within such existing and potential segments and services lines, current and potential changes in government regulation and reimbursement rules, competition for potential acquisitions and valuations of existing or potential new healthcare related facilities and operations and other factors.

Extensive competition exists for healthcare facility acquisitions, primarily from for-profit management companies and not-for-profit entities which may have greater financial and other resources than SunLink. Competition for the acquisition of non-urban acute care hospitals, related services (such as physician clinics and practices), and other healthcare facilities could have an adverse effect on our ability to acquire such healthcare businesses on favorable terms or at all.

*Going Private Strategy*

On February 5, 2013, the Company announced the commencement of a tender offer to purchase at the price of $1.50 per share in cash all of its common shares held by holders of 99 or fewer shares ( odd lots ) who owned such shares as of the close of business on February 1, 2013 ( Odd Lot Tender Offer ). In addition to the $1.50 per share price, the Company offered each eligible tendering holder a bonus of one hundred dollars

($100) upon completion of the Odd Lot Tender Offer for the tender of all shares beneficially owned by such holder which

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were received and not withdrawn prior to the date of expiration of the Odd Lot Tender offer, which was March 26, 2013. In accordance with the terms and conditions of the Offer, SunLink accepted for purchase a total of 2,631 common shares of SunLink tendered by 68 holders pursuant to the Offer. As a result of the completion of the Offer, immediately following payment for the tendered shares, the Company had approximately 9,443,000 common shares issued and outstanding and held by approximately 453 stockholders of record.

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

**Healthcare Facilities Operations**

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

- Four community hospital in three states, having an aggregate of 232 beds, each of which hospital is owned by a SunLink subsidiary;
- Two nursing homes with an aggregate of 166 beds, each of which nursing home is owned by a hospital subsidiary and located adjacent to, or in close proximity with its corresponding community hospital; and
- Our Clanton, Alabama facility which is currently vacant except for two offices rented by a physician and a testing lab.

**Owned Hospitals**

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

- Chestatee Regional Hospital ( Chestatee ), located in Dahlonega, Lumpkin County, Georgia, is a 49-licensed-bed, acute care hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations ( JCAHO ). Chestatee includes a four-bed intensive care unit ( ICU ) a 33-bed medical/surgical/pediatrics unit, and 10-bed geriatric psychiatric unit ( GPU ). Chestatee is the only hospital in its primary service area of Lumpkin and Dawson Counties.
- North Georgia Medical Center ( North Georgia ), located in Ellijay, Gilmer County, Georgia, consists of a JCAHO accredited 50-licensed-bed, acute care hospital and Gilmer Nursing Home, a 100-bed skilled nursing facility. North Georgia is the only hospital in Gilmer County. The Company has a CON to add a 10-bed inpatient geriatric psychiatric unit. North Georgia also leases a 41,985 square foot multi-purpose medical building from another SunLink subsidiary.

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

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

A subsidiary also owns the Careside Medical Park ( Careside ) hospital building located in Clanton, Chilton County, Alabama which is currently vacant except for two offices rented by a physician and a testing lab.

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**Hospital Operations**

*Utilization of Local Hospital Management Teams*

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

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

Each subsidiary hospital management team is responsible for the day-to-day operations of its hospital. Each subsidiary has access to support services, assistance, and advice in certain areas, including strategic planning, physician recruiting and relationship management, corporate compliance, reimbursement, information systems, human resources, accounting, cash management, capital financing, tax and insurance some of which may be provided by SunLink or other SunLink subsidiaries. Financial controls are maintained through the utilization of policies and procedures and monitoring by the subsidiary board of directors. Each subsidiary hospital has contracted with the HealthTrust Group Purchasing Organization, a purchasing group used by a large number of community hospitals, for certain supplies and equipment.

*Expansion of Services and Facilities*

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

*Medical Staff*

The number and quality of physicians affiliated with a hospital directly affects the quality and availability of patient care and the reputation of the hospital. Physicians generally may terminate their affiliation with a hospital at any time. Each subsidiary hospital seeks to retain primary care physicians of varied physician specialties on its medical staff to attract other qualified physicians. Physicians generally refer patients to a hospital primarily on the basis of the perceived quality of services the hospital renders to patients and physicians; the quality of other physicians on the medical staff; the location of the hospital; and the quality of the hospital s facilities, equipment and employees. Accordingly, each

subsidiary hospital strives to provide quality facilities, equipment, employees and services for physicians and their patients.

*Physician Recruiting*

Each subsidiary hospital management team is responsible for assessing the need for additional physicians, including the number and specialty of additional physicians needed by the hospital s community. Each of our local hospital management team, with the assistance of outside recruiting firms, identifies and seeks to attract

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specific physicians to its hospital s medical staff. Increasingly, each of our subsidiary hospitals has employed physicians to better align physician performance with hospital goals through employment relationships. Many hospitals and hospital systems are attempting to improve clinical and financial results by employing physicians. For newly recruited non-employed physicians, the hospital generally guarantees such physicians a minimum level of gross receipts during an initial period, generally of one year, and assists the physician s transition into the community. The physician is required to repay some or all of the amounts paid under such guarantee if the physician leaves the community within a specified period. Currently, 19 physicians are employed by our subsidiary hospitals and one is under a physician guarantee contract. Each hospital periodically evaluates each doctor and may terminate employment based on doctor performance and the needs of each facility. Physician recruiting has become more challenging and such recruiting will continue to remain challenging due to various factors including healthcare reform and market forces. The costs of recruiting and retaining physicians are also expected increase as more physicians are employed and salaries and support costs increase.

*Quality Assurance*

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

*Operating Statistics*

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

| | Fiscal Years Ended June 30, | | |
|---|---|---|---|
| | **2014** | **2013** | **2012** |
| Hospitals owned or leased at end of period | 4 | 4 | 4 |
| Licensed hospital bed (at end of period) | 232 | 232 | 232 |
| Hospital beds in service (at end of period) | 173 | 173 | 173 |
| Nursing home beds in service (at end of period) | 166 | 166 | 166 |
| Admissions | 2,961 | 3,448 | 3,525 |
| Equivalent Admissions (1) | 9,571 | 11,542 | 12,522 |
| Average Length of Stay (2) | 5.5 | 4.8 | 3.7 |
| Patient days | 16,318 | 16,708 | 12,880 |
| Adjusted patient days (3) | 54,373 | 58,346 | 44,333 |
| Occupancy rate (% of licensed beds) (4) | 19.27% | 19.73% | 15.21% |
| Occupancy rate (% of beds in service) (5) | 25.84% | 26.46% | 20.40% |
| Net patient service revenues (in thousands) | $ 71,647 | $ 74,909 | $ 74,703 |
| Net outpatient service revenues (in thousands) | $ 27,534 | $ 27,584 | $ 39,258 |
| Net revenue per equivalent admissions | $ 7,486 | $ 6,454 | $ 5,966 |
| Net outpatient service revenues (as a % of net patient service revenues) | 38.43% | 36.82% | 52.55% |

(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.

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(2) Average length of stay is calculated based on the number of patient days divided by the number of admissions.
(3) Adjusted patient days have been calculated based on a revenue-based formula of multiplying actual patient days by the sum of gross inpatient revenues and gross outpatient revenues and dividing the result by gross inpatient revenues for each subsidiary hospital. Adjusted patient days is a statistic (which is used generally in the industry) designed to communicate an approximate volume of service provided to inpatients and outpatients by converting total patient revenues to a number representing adjusted patient days.
(4) Percentages are calculated by dividing average daily census by the average number of licensed hospital beds.
(5) Percentages are calculated by dividing average daily census by the average number of hospital beds in service.

*Sources of Revenue*

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

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, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| **Source** | | | |
| Medicare | 86.8% | 80.6% | 68.3% |
| Medicaid | 3.7% | 6.5% | 10.0% |
| Private and Other Sources | 9.5% | 12.9% | 21.7% |
| | 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, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| **Source** | | | |
| Medicare | 41.0% | 39.5% | 37.2% |
| Medicaid | 21.0% | 20.4% | 22.4% |
| Private and Other Sources | 38.0% | 40.1% | 40.4% |
| | 100.0% | 100.0% | 100.0% |

Hospital revenues depend upon inpatient occupancy levels, the extent to which ancillary services and therapy programs are ordered by physicians and provided to patients, and the volume of outpatient procedures. Reimbursement rates for routine inpatient services vary significantly depending on the type of service (e.g., acute care, intensive care or psychiatric care) and the geographic location of the hospital.

The percentage of Medicare patient days increased significantly in fiscal year 2013 due to the opening of the geriatric psychiatric units

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( GPU ) at two hospital facilities. Total patient days for the two new GPUs were 28% of total patient days, or 4,671. Medicare patient days continued to increase in 2014 as a result of the GPUs volumes. GPU patient days increased to 54% of total patient days as compared to 42% for fiscal year 2014. The percentage of patient revenues attributable to outpatient services has increased in recent years, primarily as a result of medical technology advances that allow more services to be provided on an outpatient basis and from increased pressures from Medicare, Medicaid and private insurers to reduce hospital stays and provide services, where possible, on a less expensive outpatient basis.

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

**Competition**

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

- The appearance and functionality of the healthcare facilities;
- The quality and demeanor of professional staff and physicians; and
- The participation of the hospital in plans which pay a portion of the patient s bill.

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

**Managed Care**

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

location, quality and range of services, quality of medical staff, convenience and price.

The importance of obtaining contracts with managed care organizations varies from market to market, depending on the market strength of such organizations. Nevertheless, a significant portion of hospital patients in our communities in which our subsidiary hospitals operate are covered by managed care or other reimbursement programs, all of which generally pay less than established charges for hospital services.

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

**Efforts to Control Healthcare Costs**

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

**Health Care Reform**

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the Affordable Care Act or ACA ) were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. The ACA alters the United States health care system and is intended to decrease the number of uninsured Americans and reduce overall health care costs. The ACA attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance or pay a tax penalty, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments including disproportionate share payments, expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The ACA also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. Because a majority of the measures contained in the ACA have taken or are taking effect in 2013, 2014 or 2015 and many of the rules and regulations that implement the provisions of the ACA have not been finalized, it is difficult to predict the impact the ACA will have on the hospital facilities. However, we believe it is likely that the implementation or interpretation of such rules and regulations or the provisions of the ACA may have and may continue to have an adverse effect on our financial condition and results of our operations, especially since the three states in which we operate hospitals have decided not to set up state exchanges and not to expand Medicaid.

**Government Reimbursement Programs**

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

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*Medicare Inpatient Reimbursement*

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

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

DRG rate increases were 2.8% and .0.7% for FFY 2013 and 2014, respectively, and currently is 1.4% for FFY 2015. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future FFYs at rates that would be based on the market basket index, which in certain years have been, and in the future may be, subject to reduction factors. Beginning in FFY 2012 the market basket rate began to be reduced by two such reduction factors. First as required by the ACA, the market basket rate is reduced by 0.25%. Second, CMS is applying a documentation and coding adjustment to recoup a portion of perceived excess aggregate payments in FFY 2008 and FY 2009 that did not reflect actual increases in patients severity of illness. Under legislation passed in 2007, CMS was required to recoup the entire amount of FFY 2008 and 2009 excess spending resulting from changes in hospital coding practices no later than FFY 2012. If the update factor does not adequately reflect increases in the cost of providing inpatient services by our subsidiaries hospitals, our financial condition or results of operations could be negatively affected.

The ACA combined with the America Taxpayer Relief Act of 2012 ( ATRA ) made a number of changes to Medicare which include but are not limited to:

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

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

- Extension of the Medicare Dependent Hospital Program until September 30, 2013.

- Expansion, on a temporary basis, of the low volume hospital inpatient payment adjustment to include hospitals that are more than 15 miles from other healthcare facilities and have less than 1,600 discharges per year. The new temporary criteria were effective for FFYs 2011 through 2013. Effective FFY 2014, the low-volume hospital definition and payment adjustment methodology returned to the pre-FFY 2011 definition and methodology.

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

*Medicare Outpatient Reimbursement*

Most outpatient services provided by general hospitals are reimbursed by Medicare under the outpatient prospective payment system. This outpatient prospective payment system is based on a system of Ambulatory Payment Classifications ( APC ). Each APC is designed to represent a bundle of outpatient services, and each

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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 2013 the update factor was 2.6% and 2.5% for calendar year 2014 is expected to be 2.1% for calendar year 2015. If the update factor for current and future periods does not adequately reflect increases in SunLink s subsidiaries hospitals cost of providing outpatient services, our financial condition or results of operations could be negatively affected.

*Medicare Bad Debt Reimbursement*

Under Medicare, the costs attributable to the deductible and coinsurance amounts that remain unpaid by Medicare beneficiaries can be partially added to, and reimbursed as a portion of, the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the respective Medicare Auditor Contractor ( MAC ) from the prior cost report filing, and which are finally adjusted when cost reports are filed and audited.

Bad debts must meet the following criteria to be allowable:

- the debt must be related to covered services and derived from deductible and coinsurance amounts;
- the provider must be able to establish that reasonable collection efforts were made;
- the provider must be able to show the debt was actually uncollectible when claimed as worthless; and
- the provider must be able to show sound business judgment established that there was no likelihood of recovery at any time in the future.

Amounts uncollectible from specific beneficiaries are charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs was reduced by 30% prior to October 1, 2013 and will be reduced by 35% beginning FFY 2014. Under the Medicare bad debt reimbursement provisions, our subsidiaries hospitals received an aggregate of approximately $1,442, $1,261 and $1,018 for 2010, 2011 and 2012, respectively. Our hospitals reported an aggregate amount of Medicare bad debt reimbursements of approximately $1,164 for 2013. The 2013 reported amounts are subject to final settlement of the fiscal year 2013 cost reports.

*Medicare Disproportionate Share Payments*

In addition to the standard DRG payment, the Social Security Act requires that additional Medicare payments be made to hospitals with a disproportionate share of low income patients. Beneficiary Improvement and Protection Act ( BIPA ) provisions, effective for services provided on and after April 1, 2001, stipulate that rural facilities with fewer than 100 beds with a disproportionate share percentage greater than 15% will be classified as a disproportionate share hospital entitled to receive a supplemental disproportionate share payment based on gross DRG

payments. Since April 1, 2004, the effective rate has been 12.0% of DRG payments. All of our subsidiaries hospitals were classified as disproportionate share hospitals at June 30, 2014. The Affordable Care Act provides for material reductions in Medicare DSH funding. We estimate that Medicare disproportionate share payments represented approximately 1% of our net patient service revenues for the years ended June 30, 2014, 2013 and 2012.

*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.

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

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

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

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

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

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

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

*Adoption of Electronic Health Records*

Electronic Health Records ( EHR ) incentive reimbursements are payments received under the Health Information Technology for Economic and Clinical Health Act (the HITECH Act ) which was enacted into law on February 17, 2009 as part of ARRA. The HITECH Act includes provisions designed to increase the use of EHR by both physicians and hospitals. Beginning with federal fiscal year 2011 (federal fiscal year is October 1

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through September 30) and extending through federal fiscal year 2016, eligible hospitals participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of their certified EHR technology. Conversely, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to payment penalties or downward adjustments to their Medicare payments beginning in federal fiscal year 2015.

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

Attestation of Medicare meaningful use requirements was successful for each of SunLink s hospital subsidiaries and certain discontinued operations for fiscal years ended June 30, 2014, 2013 and 2012. SunLink s hospital subsidiaries have also successfully attested to the meaningful use requirements for the Medicaid program for continuing and certain discontinued operations for the fiscal years ended June 30, 2014, 2013 and 2012. EHR incentive payments received were as follows:

| | 2014 | 2013 | 2012 |
|---|---|---|---|
| **Continuing Operations** | | | |
| **Medicare** | $ 2,494 | $ 4,121 | $ 5,836 |
| **Medicaid** | 593 | 1,220 | 1,549 |
| | $ 3,087 | $ 5,341 | $ 7,385 |
| **Discontinued Operations** | | | |
| **Medicare** | $ | $ 1,136 | $ 2,685 |
| **Medicaid** | | 248 | 808 |
| | $ | $ 1,384 | $ 3,493 |
| **Combined Operations** | | | |
| **Medicare** | $ 2,494 | $ 5,257 | $ 8,521 |
| **Medicaid** | 593 | 1,468 | 2,357 |
| | $ 3,087 | $ 6,725 | $ 10,878 |

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

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

receive payments through fiscal year 2014. We currently believe we will receive minimal incentive payments in future years.

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*Government Reimbursement Program Administration and Adjustments*

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

All hospitals participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenues, costs and expenses associated with the services provided by each subsidiary hospital to Medicare beneficiaries and Medicaid recipients.

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

In 2005, CMS began using recovery audit contractors ( RACs ) to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare claims filed by healthcare providers. The RAC program was made permanent by the Tax Relief and Health Care Act of 2006. The ACA expanded the RAC program s scope to include managed Medicare and Medicaid claims, and required all states to establish programs to contract with RACs by 2011. Currently all states where our subsidiaries operate have RAC programs, and all their facilities have had requests from the various RACs to review claims. To date since the commencement of the RAC program SunLink has experienced losses in the aggregate from audit adjustments of approximately $153, $235 and $65 for the fiscal years ended June 30, 2014, 2013 and 2012, respectively.

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

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

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

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**SPECIALTY PHARMACY OPERATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

**Government Reimbursement Programs**

Our Specialty Pharmacy Business is subject to certain rules implemented by the Medicare Modernization Act ( MMA ) and, in the future may be subject to other rules previously implemented by MMA with respect to urban providers. Regulations implementing cost containment mandates under MMA reduced the reimbursement for healthcare providers in urban areas for a number of products and services which are also provided by our pharmacy operations and established a competitive bidding program for certain durable medical equipment provided under Medicare Part B in urban areas. Competitive bidding is intended to further reduce reimbursement for certain products and will likely decrease the number of companies permitted to serve Medicare beneficiaries in the competitive bidding areas ( CBAs ). CMS had planned to implement the competitive bidding program for Medicare durable medical equipment, prosthetics, orthotics, and supplies ( DMEPOS ) products and services with the goal of offering beneficiaries access to quality with lower out-of-pocket costs. Our ScriptsRx operations were exempted under the Deficit Reduction Act of 2005 from the proposed competitive acquisition program for DMEPOS, but we cannot be sure such exemption will continue to be available in the future or that the program, if expanded in the future, would be expanded in its original form. If the program is expanded in the future, loss of the exemption could have an adverse effect on our financial condition or results of operation. In 2011, Medicare implemented the program in select limited areas of the country, and, in 2013, expanded to additional areas. Currently, the areas affected do not include the primary service areas of ScriptsRx. Whether or not the program will be further expanded in the future is unknown.

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

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

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

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

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

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

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

**Competition**

There are many companies which provide one or more of the healthcare operations which comprise or may compete with our specialty pharmacy operations of ScriptsRx. For example, home healthcare business companies, which may compete with our specialty pharmacy services, our durable medical equipment services operations or both, range in size from small entrepreneurial companies to rapidly expanding companies with

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strategies for national operations, such as Amedisys, Inc., Apria Healthcare Group, Inc., Gentiva Health Services, Inc., and Walgreen Co. Specialty pharmacy companies range from local or regional pharmacies to large public companies, such as Option Care, Inc., a subsidiary of Walgreen Co., CVS Caremark Corporation, Priority Healthcare Corporation and BioScrip, Inc. Institutional pharmacy companies likewise range from local or regional pharmacies to large public companies including Omnicare, Inc. and PharMerica Corporation.

**Healthcare Regulation**

*Overview*

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

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

*Healthcare Facility Regulation*

Certificate of Need Requirements

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

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

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

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Utilization Review Compliance and Hospital Governance

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

Emergency Medical Treatment and Active Labor Act

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

*Specialty Pharmacy Segment Regulation*

Overview

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

Mail Order Activities

ScriptsRx conducts the operations of our Specialty Pharmacy Segment. In addition to walk-in customers at its retail centers, it distributes pharmaceuticals through a variety of delivery methods, including by mail and express delivery services. Many states in which ScriptsRx delivers 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.

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

Advertising and Marketing Regulations

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

*Healthcare Regulations of General Application*

Licensing Requirements

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

Drugs and Controlled Substances

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

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

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

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

- makes claims to Medicare and/or Medicaid for services not provided or misrepresents actual services provided in order to obtain higher payments;

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pays money to induce the referral of patients or the purchase of items or services where such items or services are reimbursable under a federal or state health program;

fails to report or repay improper or excess payments; or

fails to provide appropriate emergency medical screening services to any individual who comes to a hospital s campus or otherwise fails to properly treat and transfer emergency patients.

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

Sections of the Anti-Fraud and Abuse Amendments to the Social Security Act, commonly known as the anti-kickback statute, prohibit certain business practices and relationships that might influence the provision and cost of healthcare services reimbursable under Medicare, Medicaid, TriCare or other healthcare programs, including the payment or receipt of remuneration for the referral of patients whose care will be funded by Medicare or other government programs. Sanctions for violating the anti-kickback statute include criminal penalties and civil sanctions, including fines and possible exclusion from future participation in government programs, such as Medicare and Medicaid. Pursuant to the Medicare and Medicaid Patient and Program Protection Act of 1987, HHS issued regulations that create safe harbors under the anti-kickback statute. A given business arrangement that does not fall within an enumerated safe harbor is not *per se* illegal; however, business arrangements that fail to satisfy the applicable safe harbor criteria are subject to increased scrutiny by enforcement authorities.

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

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

In addition, provisions of the Social Security Act, known as the Stark Act, also prohibit physicians from referring Medicare and Medicaid patients to providers of a broad range of designated health services with which

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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 Act violations will increase in the future. Finally, many states have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients and physician self-referrals regardless of the source of the payment for the care.

The Federal False Claims Act and Similar State Laws

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

HIPAA Transaction, Privacy and Security Requirements

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

A violation of the HIPAA regulations could result in civil money penalties of $1 per incident, up to a maximum of $25 per person, per year, per standard violated. HIPAA also provides for criminal penalties of up to

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$50 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to $100 and five years in prison for obtaining protected health information under false pretenses and up to $250 and ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Since there is limited history of enforcement efforts by the federal government at this time, it is difficult to ascertain the likelihood of enforcement efforts in connection with the HIPAA regulations or the potential for fines and penalties, which may result from any violation of the regulations.

HIPAA Privacy Regulations

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

The HIPAA privacy regulations also require healthcare providers to implement and enforce privacy policies to ensure compliance with the regulations and standards. In conjunction with a private HIPAA consultant and HIPAA coordinators at each facility, individually tailored policies and procedures were developed and implemented and HIPAA privacy educational programs are presented to all employees and physicians at each facility. We believe all of our subsidiaries facilities are in compliance with current HIPAA privacy regulations.

HIPAA Electronic Data Standards

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

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

HIPAA Security Standards

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

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In conjunction with a consortium of rural hospitals, private HIPAA security consultants and HIPAA security officers at each facility, our subsidiaries have performed security assessments, and implemented individually tailored plans to apply required or addressable solutions and implemented a set of security policies and procedures. In addition, our subsidiaries developed and adopted an individually tailored comprehensive disaster contingency plan for each facility and presented a HIPAA security training program to all applicable personnel. We believe SunLink and our subsidiaries are in compliance with all aspects of the HIPAA security regulations.

HIPAA National Provider Identifier

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

ICD-10 Coding System

The Administrative Simplification Provisions of HIPAA require the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. These provisions are intended to encourage electronic commerce in the healthcare industry. HHS has issued regulations implementing the HIPAA Administrative Simplification Provisions and compliance with these regulations is mandatory for our facilities. In January 2009, CMS published a final rule regarding updated standard code sets for certain diagnoses and procedures known as ICD-10 code sets and related changes to the formats used for certain electronic transactions. While use of the ICD-10 code sets is not mandatory until October 1, 2015, our subsidiaries are modifying payment systems and processes to prepare for the implementation. The ICD-10 code sets require significant administrative changes. We believe that the cost of compliance with these regulations has not had a material adverse effect on our cash flows, financial position or results of operations. The Health Reform Law requires HHS to adopt standards for additional electronic transactions and to establish operating rules to promote uniformity in the implementation of each standardized electronic transaction.

Medical Waste Regulations

Our operations, especially our healthcare facility operations, generate medical waste that must be disposed of in compliance with federal, state and local environmental laws, rules and regulations. Our operations are also generally subject to various other environmental laws, rules and regulations. Based on our current level of operations, we do not anticipate that such compliance costs will have a material adverse effect on our cash flows, financial position or results of operations.

***Regulatory Compliance Program***

Our subsidiaries maintain a compliance programs under the direction of a risk manager. The compliance program is directed at all areas of regulatory compliance, including physician recruitment, reimbursement and cost reporting practices, as well as pharmacy and home healthcare operations. Each hospital designates a compliance officer and develops plans to correct problems should they arise. In addition, all employees are

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provided with a copy of and given an introduction to the subsidiary s *Code of Conduct*, which includes ethical and compliance guidelines and instructions about the proper resources to utilize in order to address any concerns that may arise. Each hospital conducts annual training to re-emphasize its *Code of Conduct* and monitors its compliance program to respond to developments in healthcare regulations and the industry. A toll-free hotline is also maintained to permit employees to report compliance concerns on an anonymous basis.

***Professional Liability***

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

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

**Environmental Regulation**

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

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**EXECUTIVE OFFICERS OF THE REGISTRANT**

Our executive officers, as of September 26, 2014, 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 | 65 |
| Mark J. Stockslager | Chief Financial Officer and Principal Accounting Officer | 55 |
| Byron D. Finn | President SunLink ScriptsRx, LLC | 64 |

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

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

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

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

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

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

**Consolidated Operations Risks**

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

We rely upon cash on hand, cash from operations and a subsidiary based limited revolving loan facility to fund our cash requirements for working capital, capital expenditures, commitments and payments of principal and interest on borrowings. Our ability to generate cash from operations has been negatively impacted by reduced Federal and state reimbursements, uncollectible self-pay net revenues of our Healthcare Facilities

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Segment, increased salary expenses for employed physicians and decreased patient volume at our facilities as a result of economic conditions in the locations we serve as well as decreased sales volume and earning experienced by our Specialty Pharmacy Segment. We expect that these factors will continue to have a negative impact on our business for the foreseeable future. Further deterioration would negatively impact our results of operations and cash flows.

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

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

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

For the fiscal year ended June 30, 2014, our two Georgia hospitals generated approximately 51% of consolidated gross revenues for the year. Accordingly, any adverse change in the current demographic, economic, competitive or regulatory conditions in the State of Georgia could have a material adverse effect on the business, financial condition, results of operations or prospects of SunLink.

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

SunLink has been, and will continue to be, dependent upon the services and management experience of its executive officers. If any of SunLink s executive officers were to resign their positions or otherwise be unable to serve, SunLink s management could be weakened.

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

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

licensure;

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

ownership, condition and operation of facilities;

addition of facilities and services;

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

billing for services; and

prices for services.

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These laws and regulations are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation of these laws and regulations, including in particular, Medicare and Medicaid anti-fraud and abuse amendments, codified in Section 1128B(b) of the Social Security Act and known as the anti-kickback statute. This law prohibits providers and others from soliciting, receiving, offering or paying, directly or indirectly, any remuneration with the intent to generate referrals of orders for services or items reimbursable under Medicare, Medicaid, and other federal healthcare programs.

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

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

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

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

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

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

*SunLink is and in the future could be subject to claims related to discontinued operations, including discontinued healthcare operations.*

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

insurance in the future. Based upon an evaluation of information currently available and consultation with legal counsel, management has not reserved any amounts for contingencies related to the discontinued operations.

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

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

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

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

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

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

The United States economy recently experienced a major economic recession, the economy remains relatively weak, unemployment levels remain high, and there is a substantial risk that the economy could lapse back into recession. Much healthcare spending is discretionary and can be significantly impacted by economic downturns. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. In addition, employers may impose or patients may select a high-deductible insurance plan or no insurance at all, which increases a hospital s dependence on self-pay revenue. Moreover, a greater number of uninsured patients may seek care in our emergency rooms.

We are unable to quantify the specific impact of recent or continued adverse economic conditions on our business; however we believe that the lingering effects of the economic recession have had an adverse impact on our operations. Such impact can be expected to continue to affect not only the healthcare decisions of our patients and potential patients but could also have an adverse impact on the solvency of certain managed care providers and other counterparties to transactions with us.

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

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

**Risks Related to Our Healthcare Facility Operations**

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

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

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

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

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

In addition to the physicians and management personnel whom each subsidiary s hospital employs, hospital operations are dependent on the efforts, ability, and experience of other healthcare professionals, such as nurses, pharmacists and lab technicians. Nurses, pharmacists, lab

technicians and other healthcare professionals are generally employees of an individual subsidiaries hospital. Each subsidiary s hospital s success has been, and will continue to be, influenced by its ability to attract and retain these skilled employees. A shortage of healthcare

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professionals in certain markets, the loss of some or all of its key employees or the inability to attract or retain sufficient numbers of qualified healthcare professionals could cause a hospital s operating performance to decline.

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

A significant portion of SunLink s consolidated revenues are derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. Approximately 90.5% of consolidated patient days and 62.0% of consolidated net patient revenues were derived from the Medicare and Medicaid programs for the year ended June 30, 2014. Previous legislative changes have resulted in, and future legislative changes may result in, limitations on and reduced levels of payment and reimbursement for a substantial portion of hospital procedures and costs.

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

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

Our subsidiaries hospitals have been affected by the increasing number of initiatives undertaken during the past several years by all major purchasers of healthcare, including (in addition to federal and state governments) insurance companies and employers, to revise payment methodologies and monitor healthcare expenditures in order to contain healthcare costs. Our community hospital operations derived approximately 38.0% of their consolidated net patient revenues for the fiscal year ended June 30, 2014 from private payors and other non-governmental sources who contributed approximately 9.5% of consolidated patient days. Initiatives such as managed care organizations offering prepaid and discounted medical services packages have adversely affected hospital revenue growth throughout the country and such packages represent an increasing portion of SunLink s subsidiaries admissions and outpatient revenues and have resulted in reduced revenue growth at our subsidiaries hospitals. In addition, private payers increasingly are attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations, referred to as PPOs. If our subsidiaries, specifically our hospital subsidiaries, are unable to contain costs through increased operational efficiencies and the trend toward declining reimbursements and payments continues, the results of healthcare facility segment operations and cash flow will be adversely affected and the results of our consolidated operations and our consolidated cash flow similarly likely would be adversely affected.

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

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

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

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

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

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

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

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

All states in which SunLink subsidiaries currently operate hospitals and nursing homes have laws requiring approval for the purchase, construction or expansion of various healthcare facilities including hospitals, nursing homes and ambulatory surgery centers and the provision of various services. Under such certificate of need ( CON ) laws, prior state approval is required for the acquisition of major medical equipment or the purchase, lease, construction, expansion, sale or closure of covered healthcare facilities, based on a determination of need for additional or expanded facilities or services. The failure to obtain any required CON may impair SunLink s subsidiaries ability to operate profitably.

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

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

As required by ARRA, HHS has adopted an incentive payment program for eligible hospitals and healthcare professionals that implement certified EHR technology and use it consistently with meaningful use requirements. If our subsidiaries hospitals and employed or contracted professionals do not meet the Medicare or Medicaid EHR incentive program requirements, their hospitals and clinics will not receive Medicare or Medicaid incentive payments to offset some of the costs of implementing the EHR systems. Further, beginning in federal fiscal year 2015, eligible hospitals and physicians that fail to demonstrate meaningful use of certified EHR technology will be subject to reduced payments from Medicare. Failure to implement EHR systems effectively and in a timely manner could have a material, adverse effect on our consolidated

financial position and results of operations.

Health plans and providers, including our subsidiaries hospitals, are required to transition to the new ICD-10 coding system, which greatly expands the number and detail of billing codes used for inpatient claims. Under

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current regulations, use of the ICD-10 system is required beginning October 1, 2015. Transition to the new ICD-10 system requires significant investment in coding technology and software as well as the training of staff involved in the coding and billing process. In addition to these upfront costs of transition to ICD-10, it is possible that our subsidiaries hospitals could experience disruption or delays in payment due to technical or coding errors or other implementation issues involving systems or the systems and implementation efforts of health plans and their business partners.

**Risks Relating to our Specialty Pharmacy Business**

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

For the year ended June 30, 2014, the operation by ScriptsRx of our Specialty Pharmacy Segment derived approximately 56% of its net revenues from government payors, principally Medicare and Medicaid. The Deficit Reduction Act of 2005 exempted rural providers of home care related services from the competitive acquisition program to which urban providers are subject.

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

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

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

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

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

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

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

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

Any termination of, or adverse change in, our relationships with our key suppliers, or the loss of supply of one of our key products for any other reason, could have a material adverse effect on the business of ScriptsRx and our consolidated results of operations. The largest supplier for ScriptsRx accounted for approximately 81% of the segment s cost of goods sold in the fiscal year ended June 30, 2014. Our specialty pharmacy operations have a single source of supply for many of our key products, including one product which accounted for approximately 25% of the segment s cost of goods sold in the fiscal year ended June 30, 2014. In addition, ScriptsRx has few long-term contracts with its suppliers. Arrangements with most of its suppliers may be canceled by either party, without cause and on minimal notice; and many of these arrangements are not governed by written agreements.

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

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

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

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

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

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

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

Large national companies operate in the existing market in which our Specialty Pharmacy Segment operates. We cannot assure you that one or more of such companies or other healthcare companies will not seek to compete or intensify their level of competition in the areas in which we conduct or may seek to conduct one or more of the components of the operations of our Specialty Pharmacy Segment.

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

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

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

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

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

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

**Other Risks**

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

Historically our available capital has been sufficient to meet our operating expenses, lease obligations, debt service requirements, and capital expenditures and we have managed our liquidity such that our aggregate unrestricted cash at June 30, 2014, was $3,587 and our Trace hospital subsidiary has a $1,000 revolving line of credit (of which $0 was drawn as of June 30, 2014). Future circumstances could require us to materially increase our revenues, materially reduce our expenses, or otherwise materially improve operating results, dispose of existing assets or obtain material new sources of capital in order to maintain adequate liquidity.

The Company is currently limited in its ability to raise capital, debt or equity, in the public or private markets on what it considers acceptable terms, although it is actively seeking options to provide financing for the Company s liquidity needs. Three of the Company s subsidiaries have been able to borrow money through facility based mortgages, each of which is guaranteed by the Company, utilizing USDA Rural Development

Authority guaranties, (individually, an RDA Loan and collectively, the RDA Loans ), and, in the case of our Trace hospital subsidiary, obtain a revolving working capital loan facility of $1,000. The Company and its subsidiaries currently must fund working capital needs from cash from operations or from the sale of additional assets, and we cannot assure you that we would be successful in improving our results of operations, reducing our costs, obtaining additional credit facilities or selling additional assets.

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

In the event the Company is able to deregister its common stock under the Exchange Act, holders of our securities will be subject to the risks of an investment in a private rather than a public company. We cannot tell you when or if the Company will be entitled to deregister. Upon any deregistration of our shares, our duty to file

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periodic reports with the SEC will be suspended for as long as we have fewer than 300 record shareholders, and we will no longer be a public reporting company. In addition, we will be relieved of the obligation to comply with the requirements of the proxy rules under Section 14 of the Exchange Act. When and if the Company is able to deregister, SunLink shares will no longer be listed on the NYSE Amex Equities stock exchange, and there may not be a sufficient number of shares outstanding and publicly traded following any deregistration to ensure a continued trading market in the shares in any over-the-counter market. The continued quotation of our common shares as well as the availability of any over-the-counter trading in our common shares will depend, in part, on the nature and extent of continued publicly available information about SunLink. Shareholders also could be adversely affected by a reduction in our public float, that is, the number of shares owned by outside shareholders and available for trading in the securities markets, especially if the Company makes future tender offers or private or open market purchases of its common shares. The suspension of our reporting obligations under the Exchange Act may further reduce the existing limited trading market for the Company s shares and may result in a decline in the price of the Company s shares and reduced liquidity in any trading market for our shares in the future. We may also have less access to capital markets and not be able to use the Company s shares to effect acquisitions as a non-reporting company.

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

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

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

None.

**Item 2.** ***Properties***

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

| Name or Function | Location City and State | Licensed Beds | Date of Acquisition/Lease Inception | Ownership Type |
|---|---|---|---|---|
| **Healthcare Facilities** | | | | |
| Chestatee Regional Hospital | Dahlonega, GA | 49 | February 1, 2001 | Owned |
| North Georgia Medical Center & Gilmer Nursing Home | Ellijay, GA | 50 | February 1, 2001 | Owned |
| Trace Regional Hospital & Floy Dyer Manor Nursing Home | Houston, MS | 84 | February 1, 2001 | Owned |
| Callaway Community Hospital | Fulton, MO | 49 | October 3, 2003 | Owned |
| Medical Office of North Georgia and Community Center of North Georgia (1) | Ellijay, GA | N/A | October 31, 2013 | Owned |
| **Specialty Pharmacy Operations** | | | | |
| ScriptsRx (2) | Crowley, LA | N/A | April 22, 2008 | Leased |
| ScriptsRx (3) | Lafayette, LA | N/A | April 22, 2008 | Leased |
| ScriptsRx (4) | Lake Charles, LA | N/A | April 22, 2008 | Leased |

| | | | | |
|---|---|---|---|---|
| **Other** | | | | |
| Careside Medical Park (5) | Clanton, AL | N/A | February 1, 2001 | Owned |
| Corporate Offices (6) | Atlanta, GA | N/A | June 1, 1998 | Leased |

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(1) Lease of approximately 47,500 combined square feet of medical office building and community center. The lease expires in October 2037 and is leased to a SunLink subsidiary.
(2) Lease of approximately 18,800 square feet of store location, warehouse and office space. The lease expires in April 2018 and provides for a renewal of the lease for a five-year term. Additional lease, commencing in April 2013, of approximately 1,300 square feet of office space. This lease expires in April 2015 and provides for renewal of the lease for additional one-year and three-year terms. Additional lease, commencing in August 2011, of approximately 2,400 square feet of warehouse space. This lease expires in August 2017.
(3) Lease of approximately 5,900 square feet of store location and warehouse space. The lease expires in October 2016.
(4) Lease of approximately 7,800 square feet of store location and warehouse space. The lease expires in December 2014 and provides for a renewal of the lease for a five-year term.
(5) The 62,013 square-foot hospital building is currently vacant except for two offices rented by a physician and a testing lab.
(6) Lease of approximately 4,800 square feet of office space for corporate staff. The lease expires in March 2015.

**Item 3.** ***Legal Proceedings***

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

On April 11, 2012, the Court granted SHC-Ellijay s motion for partial summary judgment and denied Defendants motions for summary judgment. In April 2012, Defendants filed a notice of appeal to the Georgia Court of Appeals. In March 2013, the Georgia Court of Appeals issued an opinion affirming in part and reversing in part the summary judgment entered for the Company. The appellate court rejected all of the Sellers various contract-law defenses. The appellate court also held that the Sellers intentionally breached the Option Agreement by failing to close the transaction and satisfy their other obligations. The appellate court reversed, however, on the question of whether Sellers breach was also willful, reasoning that willfulness carries with it an aspect of bad faith. The case has been remanded to the Superior Court for trial on the willfulness/bad faith issue and damages. A settlement has been reached pursuant to which James Garrett, as sole owner of the real property, would issue in satisfaction of the Company s claims a five year promissory note in the principal amount of $600 to Castlemark Properties, LLC, one of the Company s subsidiaries, such note to be secured by a mortgage on the real property. Such settlement is conditioned on Mr. Garrett obtaining a corrective deed from the Georgia Department of Transportation for a portion of the property. If the settlement closes, the lawsuit will be discussed and, if not, the litigation may resume. While the ultimate outcome and materiality of the litigation cannot be determined, in management s opinion the litigation should not have a material adverse effect on SunLink s financial condition or results of operations.

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

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

**Item 4.** ***Reserved***

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**PART II**

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

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

| | Sales Price of SunLink Common Shares | |
|---|---|---|
| | **High** | **Low** |
| **Fiscal 2014 (July 1, 2013 - June 30, 2014)** | | |
| Fourth Quarter | $ 1.60 | $ 1.15 |
| Third Quarter | 2.12 | 0.86 |
| Second Quarter | 0.99 | 0.70 |
| First Quarter | 0.91 | 0.70 |
| **Fiscal 2013 (July 1, 2012 - June 30, 2013)** | | |
| Fourth Quarter | $ 0.92 | $ 0.71 |
| Third Quarter | 1.26 | 0.56 |
| Second Quarter | 1.55 | 0.90 |
| First Quarter | 1.56 | 0.95 |

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

**Dividends**

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

**Holders**

As of June 30, 2014 there were approximately 453 registered holders of SunLink common shares.

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**Securities Authorized for Issuance under Equity Compensation Plans**

The following provides tabular disclosure of the number of securities at June 30, 2014 to be issued upon the exercise of outstanding options, the weighted average exercise price of outstanding options and the number of securities remaining available for future issuance under equity compensation plans, reported by two categories- plans that have been approved by shareholders and plans that have not been so approved:

| Plan Category | (a) Number of securities to be issued upon exercise of outstanding options | (b) Weighted average exercise price of outstanding options | (c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) |
|---|---|---|---|
| **Equity compensation plans approved by security holders:** | | | |
| 2005 Equity Incentive Plan | 317,999 | $ 3.73 | 412,676 |
| 2011 Director Stock Option Plan | 231,000 | 1.31 | 69,000 |
| | 548,999 | $ 2.97 | 481,676 |
| **Equity compensation plans not approved by security holders:** | | | |
| None | 0 | 0.00 | 0 |
| Total | 548,999 | $ 2.97 | 481,676 |

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**Performance Graph**

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

*$100 invested on 6/30/09 in stock or index, including reinvestment of dividends.

Fiscal year ending June 30.

| | 6/09 | 6/10 | 6/11 | 6/12 | 6/13 | 6/14 |
|---|---|---|---|---|---|---|
| **SunLink Health Systems, Inc.** | **100.00** | **103.94** | **87.56** | **55.30** | **38.25** | **56.22** |
| **NYSE Amex Composite** | **100.00** | **129.08** | **158.87** | **150.97** | **154.48** | **208.87** |
| **Hospitals Index** | **100.00** | **133.32** | **162.26** | **150.15** | **237.00** | **281.88** |

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

Selected historical financial data presented below as of and for the fiscal years ended June 30, 2014, 2013, 2012, 2011 and 2010 have been derived from the audited consolidated financial statements of SunLink. The following financial information reflects the disposition of Dexter, Chilton operations (exclusive of the physical facility), Memorial 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.

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**SunLink Selected Historical Financial Data**

(All amounts in thousands, except per share amounts)

| | 2014 | 2013 | 2012 | 2011 | 2010 |
|---|---|---|---|---|---|
| Net Revenues | $ 105,430 | $ 108,308 | $ 113,216 | $ 120,348 | $ 126,433 |
| Loss from continuing operations | (1,391) | (1,585) | (1,676) | (16,276) | (2,469) |
| Net income (loss) | (545) | 4,488 | 1,081 | (16,103) | 102 |
| Loss per share from continuing operations | | | | | |
| Basic | (0.15) | (0.17) | (0.18) | (2.01) | (0.31) |
| Diluted | (0.15) | (0.17) | (0.18) | (2.01) | (0.31) |
| Net earnings (loss) per share: | | | | | |
| Basic | (0.06) | 0.48 | 0.12 | (1.99) | 0.01 |
| Diluted | (0.06) | 0.48 | 0.12 | (1.99) | 0.01 |
| Total Assets | 63,847 | 68,003 | 79,172 | 91,830 | 98,490 |
| Long-term debt, including current maturities | 17,351 | 18,270 | 23,090 | 31,707 | 33,437 |
| Shareholders equity | $ 33,318 | $ 33,743 | $ 29,291 | $ 26,068 | $ 42,692 |

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

This Annual Report and the documents that are incorporated by reference in this Annual Report contain certain forward-looking statements within the meaning of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that do not relate solely to historical or current facts and may be identified by the use of words such as may, believe, will, seeks to , expect, project, estimate, anticipate, plan or continue. These forward-looking 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 achievements to differ materially from those anticipated, see Certain Cautionary Statements Forward Looking Information and Item 1A.

**Critical Accounting Estimates**

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

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

The table of critical accounting estimates that follows is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 2 of our Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K for the fiscal year ended June 30, 2014, 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 (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) |
|---|---|---|
| ***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:<br><br>2014 $6,903; and<br><br>2013 $7,761.<br><br>Our provision for bad debts, included in our results of operations for the years ended June 30, was as follows :<br><br>2014 $11,065;<br><br>2013 $11,770; and | 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.<br><br>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.<br><br>If net revenues during fiscal year 2014 were changed by 1%, our 2014 after-tax income from continuing operations would change by approximately $358 or diluted earnings per share of $0.04.<br><br>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. |

2012 $10,053

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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) |
|---|---|---|
| ***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.<br><br>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 subsidiaries hospitals retain third-party collection agencies for billing and collection of delinquent accounts. At most of our subsidiaries 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.<br><br>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.

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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) |
|---|---|---|
| ***Receivables-net and Provision for Bad Debts (continued)*** | 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.<br><br>In addition, we analyze other factors such as day s revenue in accounts receivable and we review admissions and charges by physicians, primarily focusing on recently recruited physicians. | |

| | Days Outstanding[1] | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Payor Class** | **0 - 30** | **31 - 60** | **61 - 90** | **91 - 120** | **121 - 150** | **151 - 180** | **>180** | **Total** |
| **Medicare** | $ 2,380 | $ 177 | $ 73 | $ 92 | $ 43 | $ 12 | $ 332 | $ 3,109 |
| **Medicaid** | 588 | 76 | 37 | 21 | 29 | 6 | 13 | 770 |
| **Commercial** | 1,156 | 437 | 201 | 173 | 44 | 37 | 110 | 2,158 |
| **Self Pay** | 93 | 94 | 76 | 67 | 61 | 15 | 82 | 488 |
| | $ 4,217 | $ 784 | $ 387 | $ 353 | $ 177 | $ 70 | $ 537 | $ 6,525 |

[1] The above table shows, as of June 30, 2014, 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 86.4%, 85.6% and 88.0% of our revenues during the years ended June 30, 2014, 2013 and 2012, respectively, relate to discounted charges. The sources of these revenues were as follows for the year ended June 30, 2014 (as a percentage of total revenues):<br><br>Medicare 41.0%;<br><br>Medicaid 21.0%; and<br><br>Commercial insurance 38.0%. | 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.<br>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 | |

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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 (continued)*** | payor specific identification and payor specific factors for rate increases and denials. | |
| | **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. | 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 (decreased) our revenues by the following amounts for the years ended June 30:<br><br>2014 $214;<br><br>2013 $(166); and<br><br>2012 $547. |
| | 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.<br><br>Final settlements under all programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely. | |
| | **Commercial Insurance** | **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 | If our overall estimated contractual discount percentage on all of our commercial revenues during 2014 were changed by 1%, our 2014 after-tax income from continuing |

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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 (continued)*** | 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. | operations would change by approximately $131. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital. |
| ***Goodwill, other intangible assets and accounting for business combinations*** | 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, the estimate of fair value is based on the income approach, which estimates the fair value based on future discounted cash flows. The estimate of future discounted cash flows is based on assumptions and projections that are believed to be currently reasonable and supportable. If it is determined the carrying value of goodwill or other intangible assets to be impaired, then the carrying value is reduced. | During the third quarter of fiscal 2012, the Company performed an interim impairment testing of the goodwill and certain intangible assets of its subsidiaries as of March 31, 2012. The Company concluded that the carrying value for its Healthmont, LLC subsidiary, part of the Healthcare Facilities Segment, exceeded its fair value, and as a result, recognized a goodwill impairment charge of $931 for such subsidiary during the year ended June 30, 2012. |

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 one reportable business segments with goodwill. Goodwill included in our consolidated balance sheets as of June 30 for the following years was as follows:

| | 2014 | 2013 |
|---|---|---|
| Pharmacy | $ 461 | $ 461 |

The goodwill resulted from the 2008 acquisition of our specialty pharmacy business.

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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 (continued)*** | | |

The Company s other 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:

| | 2014 | 2013 |
|---|---|---|
| Healthcare Facilities | | |
| Certificates of Need | $ 80 | $ 80 |
| Accumulated amortization | (28) | (26) |
| | $ 52 | $ 54 |
| Pharmacy | | |
| Trade name | $ 2,000 | $ 2,000 |
| Customer relationships | 1,089 | 1,089 |
| Medicare License | 769 | 769 |
| | 3,858 | 3,858 |
| Accumulated amortization | (879) | (737) |
| | $ 2,979 | $ 3,121 |
| Total | $ 3,031 | $ 3,175 |

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 reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

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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) |
|---|---|---|
| ***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, 2011 to February 28, 2012, March 1, 2012 to February 28, 2013, March 1, 2013 to February 28, 2014 and March 1, 2014 to February 28, 2015 our self-insured retention level is $1,000 on individual malpractice claims.<br><br>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.<br><br>The reserve for professional and general liability claims included in our consolidated balance sheets as of June 30 was as follows:<br><br>2014 $1,268; and<br><br>2013 $2,461.<br><br>The total increases (decreases) for professional and general liability coverage, included in our consolidated results of operations for the years ended June 30, was as follows:<br><br>2014 $(272); | 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.<br><br>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.<br><br>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 | 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.<br><br>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. |

2013 $154; and

2012 $954.

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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) |
|---|---|---|
| ***Professional and general liability claims (continued)*** | | |
| | place or if similar laws are passed in the states where our other 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. | |
| ***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: | 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. | Our deferred tax assets were $9,987 and our deferred tax liabilities were $0 at June 30, 2014, excluding the impact of valuation allowances. The Company believes that it was more likely than not that a portion of its deferred tax asset would not be recovered. |
| 2014 $7,410; and<br>2013 $8,121. | 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. | 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 income for 2014, we would incur approximately $235 of additional tax expense for 2014 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: | | |
| 2014 $2,577; and<br>2013 $2,151. | 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 | |
| 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

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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) |
|---|---|---|
| *Accounting for income taxes (continued)* | | |
| 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. | 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. | |
| 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. | 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. | |

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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, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Net Revenues Healthcare Facilities | $ 71,647 | $ 74,909 | $ 74,703 |
| Net Revenues Specialty Pharmacy | 33,322 | 33,314 | 38,099 |
| Net Revenues Corporate and Other | 461 | 85 | 414 |
| Total Net Revenues | 105,430 | 108,308 | 113,216 |
| Costs and expenses | (109,381) | (113,561) | (117,423) |
| Electronic health records incentives | 3,911 | 4,947 | 7,294 |
| Impairment of goodwill and intangible assets | 0 | 0 | (931) |
| Impairment of plant, property and equipment | 0 | (789) | 0 |
| Operating Profit (Loss) | (40) | (1,095) | 2,156 |
| Interest Expense | (1,220) | (1,796) | (4,377) |
| Loss on sale of assets | (43) | 0 | (20) |
| Loss from continuing operations before income taxes | $ (1,303) | $ (2,891) | $ (2,241) |
| Healthcare Facilities Segment: | | | |
| Admissions | 2,961 | 3,448 | 3,525 |
| Equivalent Admisssions | 9,571 | 11,542 | 12,522 |
| Surgeries | 2,012 | 1,762 | 1,825 |
| Revenue per Equivalent Admission | $ 7,486 | $ 6,490 | $ 5,966 |

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, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| **Source** | | | |
| Medicare | 41.0% | 39.5% | 37.2% |
| Medicaid | 21.0% | 20.4% | 22.4% |
| Self pay | 13.6% | 14.4% | 11.9% |
| Commercial Insurance & Other | 24.4% | 25.7% | 28.5% |
| | 100.0% | 100.0% | 100.0% |

*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.

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Healthcare Facilities Segment

The 4.4% decrease in net revenues for the year ended June 30, 2014 from 2013 was due primarily to decreased net revenues in all payor classes, especially Self-pay revenues and Commercial Insurance & Other revenues, as a result of a decline in inpatient volume. Commercial insurance and other decreased $1,638, a 7.6% decrease from prior year. Self-pay revenues decreased $1,272, a 10.2% decrease from prior year. Net revenues for the fiscal year ended June 30, 2014 included revenues of $573 for the settlements and filings of prior year Medicare and Medicaid cost reports compared to reductions of $166 for the fiscal year ended June 30, 2013. Net outpatient service revenues increased from 36.8% of healthcare facilities segment net revenue to 38.4% as compared to the prior fiscal year. Net revenues for the fiscal year ended June 30, 2014, 2013 and 2012, included $2,637, $2,338 and $2,540 respectively, from state indigent care programs.

A decrease in the number of doctors and the elimination of certain unprofitable services at three of SunLink s hospitals combined with an overall decline in volumes have contributed to the decrease in Healthcare Facilities Segment net revenues in the years ended June 30, 2014, 2013 and 2012, respectively. We experienced a net reduction of one and two doctors during the fiscal years ended June 30, 2014 and 2013, respectively. During the fiscal year ended June 30, 2014, SunLink expensed $110 of physician guarantees and recruiting costs compared to $137 and $340 in fiscal years 2013 and 2012, respectively. We also have expended approximately $8,216 for capital expenditures to upgrade services and facilities since July 1, 2011. We believe upgraded services and facilities can contribute to an increase in net revenue per equivalent admission by attracting new patients and may mitigate decreases in net revenues per equivalent admission by limiting the loss of patients to competition from other facilities. We continue to seek increased patient volume by attracting additional physicians to our hospitals, adding and 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.

Specialty Pharmacy Segment

Net revenues for the year ended June 30, 2014 remained consistent with the prior year net revenues; however, fiscal 2014 included a net increase in pharmacy net revenues of $957 due primarily to additional institutional pharmacy contracts and a net decline in durable medical equipment sales of $949 due primarily to the elimination of certain unprofitable items. Although fiscal 2014 retail and institutional pharmacy script volumes increased 8.7% as compared to fiscal 2013, the corresponding pharmacy net revenues decreased 4.1%, primarily as a result of decreases in reimbursement rates, including Medicare, Medicaid and managed care; the negative effects of significant brand-to-generic conversion activity; and, a significant increase in exclusive preferred provider network arrangements between major pharmacy benefit managers and certain retail chain pharmacies. Fiscal 2014 infusion therapy net revenues increased 2.0% as compared to fiscal 2013, primarily related to certain higher reimbursed specialty pharmacy services. Fiscal 2013 net revenues decreased $4,785, or 12.5%, as compared to fiscal 2012 net revenues as a result of a net decline in pharmacy net revenues of $4,297 and a decrease in durable medical equipment sales of $488. Although fiscal 2013 retail and institutional pharmacy script volumes increased 6.9% as compared to fiscal 2012, the corresponding pharmacy net revenues decreased 10.6%, primarily as a result of decreases in reimbursement rates, including Medicare, Medicaid and managed care; the negative effects of significant brand-to-generic conversion activity; and, the loss of a pharmacy services management contract with a group of long-term care facilities. Fiscal 2013 infusion therapy net revenues decreased 25.1% as compared to fiscal 2012, primarily related to one infusion therapy drug prescribed for premature babies at high risk for lung disease. Fiscal 2012 net revenues decreased $1,821, or 4.8%, as compared to fiscal 2011. The decrease was primarily a result of a net decline in pharmacy net revenues of $1,533 and a decrease in durable medical equipment sales of $288. Although retail pharmacy net revenues increased 19.1%, institutional pharmacy net revenues decreased 16.9%, primarily as a result of the net loss of pharmacy services contracts with a group of affiliated long-term care facilities, and infusion therapy net revenues decreased 10.6%, primarily related to one infusion therapy drug prescribed for premature babies at high risk for lung disease. Generally, Medicare and Medicaid reimbursement rates decreased in fiscal 2012 as compared to fiscal 2011, contributing to the decline in net revenues.

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Healthcare Facilities Segment Cost and Expenses

Costs and expenses for our Healthcare Facilities, including depreciation and amortization, were $67,416, $69,887, and $67,473, for the fiscal years ended June 30, 2014, 2013 and 2012, respectively.

| | Cost and Expenses as a % of Net Revenue Years Ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Salaries, wages and benefits | 58.9% | 57.6% | 56.5% |
| Supplies | 11.7% | 11.9% | 11.0% |
| Purchased services | 10.5% | 8.3% | 8.7% |
| EHR incentive payments | -5.5% | -6.6% | -9.8% |
| Other operating expenses | 16.0% | 17.1% | 17.3% |
| Rent and lease expense | 2.4% | 2.3% | 2.1% |
| Depreciation and amortization expense | 2.9% | 3.3% | 4.0% |

Salaries, wages and benefits expense increased as a percentage of net revenue in the year ended June 30, 2014 due to expansion of services at two hospitals requiring more employees in these service areas and an increase in employee medical claims incurred as compared to the prior year. Salaries, wages and benefits expense as a percentage of total net revenues increased in the year ended June 30, 2013 compared to the prior year due to expansion of services at two hospitals requiring more employees in these service areas and an increase in employee medical claims incurred as compared to the prior year.

Supplies expense as a percentage of net revenue remained consistent for the fiscal years ended June 30, 2014 and 2013. Supplies expense increased as a percentage of net revenue in the year ended June 30, 2013 due to expansion of services at two hospitals and an increase in the number of orthopedic surgeries performed as compared to the prior year. Supplies expense decreased as a percentage of net revenue in the year ended June 30, 2012 due to a decrease in the number of surgeries performed combined with overall decline in volume as compared to the prior year. Surgeries for the year ended June 30, 2012 were 1,825 compared to 2,298 for the prior year period. The elimination and reduction of services at selected hospitals of the Company also contributed to the decline in supplies expense.

Purchased services increased as a percentage of net revenues for the fiscal year ended June 30, 2014 compared to the prior fiscal year due to increased costs associated with certain outside services provided to the hospital facilities and information technology services. Purchased services as a percentage of net revenue remained consistent for the fiscal years ended June 30, 2013 and 2012.

EHR incentive payments as a percentage of net revenue are a negative 5.5%, 6.6% and 9.8% for the fiscal years ended June 30, 2014, 2013 and 2012. The decreases are related to the $3,568 and $343, respectively, of Medicare and Medicaid EHR incentive payments recognized in the year ended June 30, 2014, the $3,726 and $1,221, respectively, of Medicare and Medicaid EHR incentive payments recognized in the year ended June 30, 2013 and the $6,022 and $1,272, respectively, of Medicare and Medicaid EHR incentive payments recognized in the year ended June 30, 2012.

For the year ended June 30, 2014, other operating expenses as a percentage of net revenue decreased from prior year. Other operating expenses decreased due to decreased professional and general liability insurance expense as a result of improved claims experience and nonrecurrence of large insurance settlement claims recorded in the prior year. For the year ended June 30, 2013, other operating expenses as a percentage of net

revenue remained consistent with prior year. Other operating expenses increased as a percentage of net revenues in the year ended June 30, 2012 compared to the prior year due to lower net patient revenues in the current year.

Depreciation and amortization expense was $2,076, $2,493, and $2,642 for the years ended June 30, 2014, 2013, and 2012, respectively. The decreases in depreciation and amortization expense resulted from assets being fully over the past several years.

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Specialty Pharmacy Segment Cost and Expenses

Cost and expenses for our Specialty Pharmacy Segment, including depreciation and amortization, was $32,839, $33,150 and $37,641 for the fiscal years ended June 30, 2014, 2013 and 2012, respectively.

| | Cost and Expenses as a % of Net Revenue Years Ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Cost of goods sold | 66.4% | 67.1% | 68.4% |
| Salaries, wages and benefits | 20.9% | 20.2% | 18.2% |
| Provision for bad debts | 0.8% | 1.4% | 1.6% |
| Supplies | 0.5% | 0.6% | 0.6% |
| Purchased services | 3.8% | 3.8% | 3.5% |
| Other operating expenses | 3.3% | 3.3% | 3.5% |
| Rent and lease expense | 0.9% | 0.9% | 0.8% |
| Depreciation and amortization expense | 2.2% | 2.2% | 2.1% |

Cost of goods sold as a percent of net revenues decreased in the fiscal years ended June 30, 2014, 2013 and 2012 as compared to the respective prior fiscal years due to changes in sales product mix and favorable pricing negotiations and discounts earned with certain suppliers.

Salaries, wages and benefits increased as a percent of net revenues in the fiscal years ended June 30, 2013 and 2012 as compared to the respective prior fiscal years primarily due to decreased net revenues.

The decrease in the provision for bad debts as a percent of net revenues during the fiscal years ended June 30, 2014, 2013 and 2012 as compared to the respective prior fiscal years resulted from improved business office operational and procedural controls and practices and enhanced claims management, improved collections of accounts receivable and reduced uncollectible account write-offs.

Depreciation and amortization expense decreased for the fiscal year ended June 30, 2012 as compared to the prior fiscal year due to impairment of certain intangible assets during fiscal 2011 which decreased the amount of annual amortization on the remaining intangible assets. Amortization expense for fiscal 2012 was $142 as compared to $585 in fiscal 2011.

Corporate Overhead Costs and Expenses

Cost and expenses for Corporate Overhead including depreciation and amortization, was $5,215, $5,577 and $5,946 for the fiscal years ended June 30, 2014, 2013 and 2012, respectively. The decrease in the fiscal year ended June 30, 2014 from the prior year was due to decreased salaries and legal expense. The decrease in the fiscal year ended June 30, 2013 from the prior year was due primarily to staff reductions in January 2013.

Impairment of Long-Lived Assets

A hospital facility and related equipment in Clanton, Alabama, formerly leased to a third party hospital operator is currently vacant with the exception of three leased offices. The net realizable value of the hospital and equipment was evaluated and it was determined that an impairment of the net value of the leased property, plant and equipment had occurred. An impairment charge of $789 was recognized during the first quarter of fiscal 2013.

Impairment of Goodwill and Intangible Assets

The Company performed an interim impairment testing of the goodwill and certain intangible assets of its subsidiaries in the third quarter of fiscal year 2012. The Company concluded that the carrying value of the Healthmont, LLC subsidiary, part of the Healthcare Facilities Segment, exceeded its fair value, and as a result, recognized a goodwill impairment charge of $931 for such subsidiary for the fiscal year ended June 30, 2012.

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Operating Profit (Loss)

Operating loss was $40 for the year ended June 30, 2014, $1,095 for the year ended June 30, 2013 and operating profit for the year end June 30, 2012 was $2,156. The decreased operating loss for the year ended June 30, 2014 compared to the prior year was the result of lower operating expenses and the absence of an impairment charge to property, plant and equipment partially offset by lower net revenues and EHR incentive payments. The operating loss for the year ended June 30, 2013 compared to the prior year operating profit was the result of lower net revenues and EHR incentive payments partially offset by lower cost of goods sold and decreases in certain other operating expenses. The net effect of the EHR incentives payments and the absence of an impairment charge for the Specialty Pharmacy Segment for the year ended June 30, 2012 was partially offset by lower operating profit due to a decrease in net revenues for the Healthcare Facilities and Specialty Pharmacy Segments and a goodwill impairment charge of $931 for our Healthmont, LLC subsidiary.

Interest Expense net

Interest expense was $1,220, $1,796, and $4,377 for the years ended June 30, 2014, 2013 and, 2012, respectively. The decreases in interest expense for the years ended June 30, 2014 and 2013 was due to lower outstanding debt and a decrease in interest rates.

Income Taxes

We recorded income tax expense of $88 ($402 federal tax benefit and $490 state tax expense) for the year ended June 30, 2013 compared to income tax benefit of $1,305 ($1,210 federal tax benefit and $95 state tax benefit) for the year ended June 30, 2013 and income tax benefit of $565 ($556 federal tax benefit and $9 state tax benefit) for the year ended June 30, 2012.

We had an estimated net operating loss carry-forward for federal income tax purposes of approximately $5,553 at June 30, 2014. 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 $2,577 of our $9,987 gross deferred tax asset (the majority of which is the net operating loss carry-forward for federal and state income tax purposes). Based upon management s assessment that it was more likely than not that a portion of the Company s 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 tax asset which may not be utilized.

Earnings (Loss) After Taxes

Loss from continuing operations was $1,391 ($0.15 loss per fully diluted share) for the year ended June 30, 2014 compared to a loss from continuing operations of $1,585 ($0.17 loss per fully diluted share) for the year ended June 30, 2013 and loss from continuing operations of $1,676 ($0.18 loss per fully diluted share) for the year ended June 30, 2012. Loss from continuing operations in fiscal year 2013 resulted from decreased net revenues for the Healthcare Facilities and Specialty Pharmacy Segments partially offset by decreased cost of goods sold, the recognition of $4,947 in EHR incentive payments and a decrease in interest expense of $2,594 from prior year. Loss from continuing operations in fiscal year 2012 resulted from decreased net revenue partially offset by the recognition of $7,294 in EHR incentive payments and $3,042 decrease in interest from prior year. 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 over the prior year.

Earnings from discontinued operations of $846 for the year ended June 30, 2014 primarily resulted from $1,548 of pre-tax earnings from the operations of Dexter (including $1.076 of Medicare EHR incentive payments), $94 of pre-tax loss from operations of Memorial and $158 of pre-tax loss resulting from domestic pension items . Earnings from discontinued operations of $6,073 for the year ended June 30, 2013 primarily

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resulted from $542 of pre-tax earnings from the operations of Dexter, $26 of pre-tax loss from operations of Memorial, the $253 of pre-tax loss resulting from domestic pension items and pre-tax gains of $9,289 and $1,161 on the sale of Dexter and Memorial, respectively. Earnings from discontinued operations of $2,757 for the year ended June 30, 2012 primarily resulted from $3,750 of pre-tax earnings from the operations of Dexter, pre-tax earnings from operations of Memorial of $445 and the $88 of pre-tax loss resulting from domestic pension items.

Net loss for the year ended June 30, 2014 was $545 ($0.06 loss per fully diluted share) compared to net earnings for the year ended June 30, 2013 of $4,488 ($0.48 earnings per fully diluted share) and net earnings of $1,081 ($0.12 earnings per fully diluted share) for the year ended June 30, 2012.

**Adjusted 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, 2014, 2013 and 2012, respectively, is shown below.

| | Years ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Healthcare Facilities Adjusted EBITDA | $ 6,308 | $ 6,728 | $ 10,739 |
| Specialty Pharmacy Adjusted EBITDA | 1,212 | 892 | 1,273 |
| Corporate overhead costs | (3,898) | (3,877) | (4,558) |
| Taxes and net interest expense | (1,757) | (5,131) | (5,163) |
| Other non-cash expenses and net changes in operating assets and liabilities | 2,027 | (628) | 791 |
| Net cash provided by (used in) operations | $ 3,892 | $ (2,016) | $ 3,082 |

**Liquidity and Capital Resources**

*Overview*

Our primary sources of liquidity are cash on hand and one facility-based revolving loan facility of $1,000 through September 30, 2014 declining in increments to $500 at July 1, 2015 which has limited availability due to facility cash on hand restrictions. The Company does not believe it is currently able to raise capital, debt or equity, in the public or private markets on what it considers acceptable terms, however, it is actively seeking options to provide financing for the Company s liquidity needs.

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Although three of the Company s subsidiaries have been able to borrow money through facility based mortgages, each of which is guaranteed by the Company, utilizing USDA Rural Development Authority guaranties, (individually, an RDA Loan and collectively, the RDA Loans ), and, in the case of our Trace hospital subsidiary, obtain a revolving working capital loan facility of $1,000, the Company and its subsidiaries currently must fund working capital needs from cash from operations or from the sale of additional assets. See Subsidiary Loans below.

As further discussed below, on December 31, 2012, in connection with the maturity of the Company s then existing Credit Facility, the Company repaid all then outstanding borrowings thereunder and such facility terminated. The total amount repaid at maturity including associated fees was approximately $5,000. If we are able to obtain a replacement credit facility in the future, there is no assurance as to the timing of the implementation of any such replacement facility or that the size of any such facility would be adequate for our entire working capital needs. See Termination and Repayment of Credit Facility below.

During the fiscal 2013, the Company sold two of its hospital facilities resulting in a net gain after taxes of approximately $5,000. See Discontinued Operations below. Substantially all net proceeds of the sales were used to pay down debt.

The Company believes its hospital facilities are currently underperforming. The Company has incurred losses from continuing operations in eleven of the last twelve fiscal quarters through June 30, 2014. The Company lost $1,391 from continuing operations in the year ended June 30, 2014 after recognition of EHR incentive payments of $3,911 (which payments diminished significantly in fiscal 2014 and end for Medicare in fiscal 2015). Continuing losses from operations may have a material adverse effect on our liquidity.

In light of the conintuing underperformance of the Company s four current hospital facilities, the Company has engaged advisors to evaluate and advise it on the possible sale of two such hospital facilities. There can be no assurance any sale will occur or that, if a sale occurs, it will be at a price that results in a gain or net proceeds after transaction costs, taxes and outstanding debt. The Company expects to use a portion of the net proceeds, if any, from future asset sales to fund its working capital needs because its remaining hospitals and its specialty pharmacy segment are not currently providing sufficient cash flow to fund working capital.

Subject to the risks and uncertainties discussed herein, we believe we have adequate financing and liquidity to support our current level of operations through the next twelve months.

*Termination and Repayment of Credit Facility*

On April 23, 2008, SunLink and substantially all of its subsidiaries entered into a $47,000 seven-year senior secured credit facility ( Credit Facility ) initially 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 was subsequently amended by eight modification agreements as a result of which the Revolving Loan commitment was reduced to $9,000 as of September 20, 2012 and the termination date of the Credit Facility was established as January 1, 2013. As of December 31, 2012, the Company paid all outstanding amounts under the Revolving Loan and the Term Loan and the Credit Facility was terminated.

*Subsidiary Loans*

***Callaway RDA Loan*** SunLink, HealthMont of Missouri, LLC ( HOM ) and HealthMont LLC ( HLLC ), the direct parent of HOM closed on a $5,000 Loan Agreement dated as of March 16, 2012 (the Callaway RDA Loan ) with a bank. HealthMont of Missouri, LLC owns and operates Callaway Community Hospital ( Callaway ) in Fulton, Missouri. The Loan Agreement consists of a $4,000 term loan and $1,000 construction loan. The $4,000 term loan was drawn in its entirety at closing and, as of June 30, 2014, the entirety of the $1,000 construction loan has been drawn. The Callaway RDA Loan is guaranteed by HLLC and the Company.

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The Callaway RDA Loan has a term of 25 years with monthly payments of principal and interest. The Callaway RDA Loan bears a floating interest rate equal to the prime rate (as published in The Wall Street Journal) plus 2% (5.25% at June 30, 2014). The Callaway RDA Loan is collateralized by Callaway s real estate and equipment and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program. Of the Callaway RDA Loan proceeds, $3,250 was applied as payment against the Company s then outstanding Credit Facility. Approximately $1,000 of the Callaway RDA Loan proceeds were used to finance improvements, including to provide an inpatient geriatric psychiatry unit and an emergency department upgrade, with the remainder of the Callaway RDA Loan proceeds used for working capital and closing costs. Drawn but unused loan proceeds of $92 were included on the balance sheet at June 30, 2013 as cash in escrow.

The Callaway RDA Loan contains certain financial covenants with respect to the ratio of current assets to current liabilities and debt service coverage, all as defined in the Callaway RDA Loan Agreement and measured at the end of each fiscal year. At June 30, 2014, Callaway was not in compliance with the funded debt to EBITDA ratio. The Company is currently discussing a modification or waiver of this non-compliance with the lender but has been unable to obtain such waiver as of September 26, 2014. As a result, the amount of indebtedness under the Callaway RDA Loan of $4,801 is presented in current liabilities in the consolidated balance sheet as of June 30, 2014. If Callaway is unable to obtain a waiver of the non-compliance, the lender under the Callaway RDA Loan would, among other things, be entitled to call a default and demand repayment of the indebtedness outstanding from Callaway or from the Company under its guarantee of such indebtedness. The ability of Callaway and the Company to make the required debt service under the Callaway RDA Loan depends on, among other things, the ability of Callaway and the Company to generate sufficient cash flows, including from operating activities. If Callaway or the Company are unable to generate sufficient cash flow from operations to meet debt service on the Callaway RDA loan or the guarantee, including in the event the lender were to declare an event of default and accelerate the maturity of the indebtedness, such failure could have material adverse effects on the Company. Although Callaway and the Company believe they will be able to negotiate a waiver, the Company cannot assure you that a waiver will be obtained or the timing thereof.

***Trace RDA Loan and Trace Working Capital Loan*** On July 11, 2012, SunLink, Crown Healthcare Investments, LLC (formerly known as MedCare South, LLC) ( Crown ) and Southern Health Corporation of Houston, Inc. ( SHCH ), an indirect wholly-owned subsidiary of the Company, closed on a $9,975 Mortgage Loan Agreement dated as of July 5, 2012 ( Trace RDA Loan ) and up to a $1,000 Working Capital Loan Agreement dated as of July 5, 2012 ( Trace Working Capital Loan ) with a bank. The Trace Working Capital Loan was amended by the Third Amendment to Loan Agreement and Waiver effective June 30, 2014. SHCH owns and operates Trace Regional Hospital Trace ) in Houston, Mississippi. Both the Trace RDA Loan and the Trace Working Capital Loan are unconditionally guaranteed by the Company and Crown.

The Trace RDA Loan has a term of 15 years with monthly payments of principal and interest until repaid. The Trace RDA Loan bears a floating rate of interest equal to the greater of (i) the prime rate (as published in The Wall Street Journal) plus 1.5%, or (ii) 6% (6.0% at June 30, 2014). The Trace RDA Loan is collateralized by Trace s real estate and equipment and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program. Approximately $8,500 of the Trace RDA Loan proceeds was used to repay a portion of the Company s senior debt under the Term Loan under the then outstanding Credit Facility. Approximately $850 of the Trace RDA Loan proceeds were used for improvements to the hospital and its medical office building with the remainder of the loan proceeds used for working capital and closing costs. Drawn but unused loan proceeds of $68 were included on the balance sheet at June 30, 2013 as cash in escrow.

The Trace Working Capital Loan as amended provides for a revolving line of credit to SHCH equal to the lesser of (i) a Borrowing Base equal to eighty percent (80%) of Eligible Accounts Receivable (as defined in the Working Capital Loan Agreement dated July 5, 2012) or (ii) (a) prior to September 31, 2014, $1,000; (b) for the quarter ending December 31, 2014, $875; (c) for the quarter ended March 31, 2015, $750; (d) for the quarter ending June 30, 2014, $625; and (e) thereafter, $500. The Trace Working Capital Loan expires July 2, 2015. It is subject to annual renewal at the discretion of the lender. At June 30, 2014, there were no outstanding borrowings under the Trace Working Capital Loan.

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The Trace RDA Loan contains various terms and conditions, including financial restrictions and limitations, and affirmative and negative covenants. The covenants include financial covenants measured on a quarterly basis which require our SHCH subsidiary to comply with a ratio of current assets to current liabilities, debt service coverage, fixed charge coverage, and funded debt to EBITDA, all as defined in the Trace RDA Loan. At March 31, 2014, SHCH was not in compliance with the debt to tangible net worth ratio. The Company received a waiver of this non-compliance from the lender effective June 30, 2014, and the Trace RDA Loan was amended effective June 30, 2014 by the Third Amendment to Loan Agreement and Waiver ( Third Amendment ). Under the Third Amendment, the funded debt to EBITDA ratio limits were modified. Although SHCH and the Company believe they will be able to continue in compliance with the revised levels of financial covenants in the Trace RDA Loan, there is no assurance that SHCH and the Company will be able to do so.

***SHPP RDA Loan*** On October 31, 2012, SunLink Healthcare Professional Property, LLC closed on a $2,100 term loan dated as of October 31, 2012 (the SHPP RDA Loan ) with a bank. SHPP owns and leases a medical office building to Southern Health Corporation of Ellijay, Inc. ( SHC Ellijay ). SHC Ellijay owns and operates North Georgia Medical Center ( North Georgia ), located in Ellijay, Georgia.

The SHPP RDA Loan has a term of 25 years with monthly payments of principal and interest until repaid. The SHPP RDA Loan bears interest at a floating rate of interest equal to the greater of (i) the prime rate (as published in The Wall Street Journal) plus 2.0%, or (ii) 5% (5.25% at June 30, 2013). The SHPP RDA Loan is collateralized by SHPP s real estate, equipment and leases and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program. Of the SHPP RDA Loan proceeds, $1,800 was used by SHC Ellijay to acquire a medical office building in Ellijay, Georgia which was then sold to SHPP, with the remainder of the SHPP RDA Loan proceeds used for SHPP working capital and closing costs. The SHPP RDA Loan contains certain financial covenants with respect to the ratio of current assets to current liabilities and debt service coverage, all as defined in the SHPP RDA Loan Agreement, which SHPP must maintain and that are measured at the end of each fiscal year. The SHPP RDA Loan is guaranteed by the Company and MedCare.

***Carmichael Notes*** On April 22, 2008, SunLink Scripts Rx, LLC entered into a $3,000 promissory note agreement with an interest rate of 8% with the former owners of Carmichael as part of the acquisition purchase price (the Carmichael Purchase Note ). On April 12, 2012, an amendment to the Carmichael Purchase Note was entered into under which SunLink has the option to issue 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 Purchase Note (the PIK Notes ). The PIK Notes bear an interest rate of 8% and were to be due on April 22, 2015. A PIK Note for $247 was issued on April 22, 2012 for the principal and interest payment that would have been due on April 22, 2012. A PIK Note for $252 was issued on October 22, 2012 for the principal and interest payment that would have been due on October 22, 2012. The Carmichael Purchase Note and the PIK Notes were combined into one note (the Carmichael Note dated April 22, 2014 for the remaining balance payable of $1,852. The Carmichael Note is payable in one interest only payment of $75 due on October 22, 2014 and five semi-annual installments of $185 of principal and accrued interest commencing on April 22, 2015, with the remaining balance of the Carmichael Note of $1,255 due October 22, 2017. Interest is payable in arrears semi-annually on the six and twelve-month anniversary of the issuance of the note. The Carmichael Note is guaranteed by the Company.

We generated $3,892 of cash from continuing operations during the year ended June 30, 2014. Cash generated resulted from the receipt of EHR incentive reimbursements of $3,087, income tax refunds of $1,881 from continuing operations partially offset by increases in third party payor settlements and reductions in prepaid expenses and other assets.

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**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, 2014 is shown in the following table. The interest on variable interest debt is calculated at the interest rate in effect at June 30, 2014.

| Payments due in: | Long-Term Debt | Operating Leases | Interest on Long-Term Debt |
|---|---|---|---|
| 1 year | $ 5,378 | $ 1,549 | $ 981 |
| 2 years | 767 | 847 | 731 |
| 3 years | 808 | 700 | 678 |
| 4 years | 1,839 | 281 | 577 |
| 5 years | 620 | 29 | 490 |
| More than 5 years | 7,939 | 11 | 2,771 |
| | $ 17,351 | $ 3,417 | $ 6,228 |

***Physician Guarantees*** At June 30, 2014, SunLink had a guarantee agreement with one physician. 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 this one guarantee have been paid as of June 30, 2014. SunLink expensed $110, $137, and $340, for the fiscal years ended June 30, 2014, 2013 and 2012, respectively. There were no remaining non-cancelable commitments under guarantee agreements with physicians as of June 30, 2014.

***Long-term Debt*** At June 30, 2014, we had outstanding long-term debt of $17,351 of which $4,801 was incurred under the Callaway RDA Loan, $8,624 was incurred under the Trace RDA Loan, $2,033 was incurred under the SHPP RDA Loan, $1,852 was incurred under the Carmichael Notes, and $41 was related to capital leases. At June 30, 2013, we had outstanding long-term debt of $18,270 of which $4,908 was incurred under the Callaway RDA Loan, $9,047 was incurred under the Trace RDA Loan, $2,073 was incurred under the SHPP RDA Loan, $2,152 was incurred under the Carmichael Notes, and $90 was related to capital leases.

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

On April 11, 2012, the Court granted SHC-Ellijay s motion for partial summary judgment and denied Defendants motions for summary judgment. In April 2012, Defendants filed a notice of appeal to the Georgia Court of Appeals. In March 2013, the Georgia Court of Appeals issued an opinion affirming in part and reversing in part the summary judgment entered for the Company. The appellate court rejected all of the Sellers various contract-law defenses. The appellate court also held that the Sellers intentionally breached the Option Agreement by failing to close the transaction and satisfy their other obligations. The appellate court reversed, however, on the question of whether Sellers breach was also willful, reasoning that willfulness carries with it an aspect of bad faith. The case has been remanded to the Superior Court for trial on the

willfulness/bad faith issue and damages.

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A settlement has been pursuant to which James Garrett, as sole owner of the real property, would issue in satisfaction of the Company s claims a five year promissory note in the principal amount of $600 to Castlemark Properties, LLC, one of the Company s subsidiaries, such note to be secured by a mortgage on the real property. Such settlement is conditioned on Mr. Garrett obtaining a corrective deed from the Georgia Department of Transportation for a portion of the property. If the settlement closes, the lawsuit will be discussed and, if not, the litigation may resume. While the ultimate outcome and materiality of the litigation cannot be determined, in management s opinion the litigation should not have a material adverse effect on SunLink s financial condition or results of operations.

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

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

**Recent Accounting Pronouncements**

In August 2014, the Financial Accounting Standards Board ( FASB ) issued Accounting Standards Update ( ASU ) 2014-15 Disclosure of Uncertainties about an Entity s Ability to Continue as a Going Concern ( ASU 2014-15 ). ASU 2014-15 will explicitly require management to assess an entity s ability to continue as a going concern, and to provide related footnote disclosure in certain circumstances. The new standard will be effective for all entities in the first annual period ending after December 15, 2016. Earlier adoption is permitted. We are currently evaluating the impact of the adoption of ASU 2014-15.

In April 2014, the FASB issued ASU 2014-08, Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity, ( ASU 2014-08 ). Under ASU 2014-08, only disposals representing a strategic shift in operations that have a major effect on the Company s operations and financial results should be presented as discontinued operations. Additionally, ASU 2014-08 requires expanded disclosures about discontinued operations that will provide financial statement users with more information about the assets, liabilities, income, and expenses of discontinued operations. The amendments in ASU 2014-08 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2014. However, ASU 2014-08 should not be applied to a component that is classified as held for sale before the effective date even if the component is disposed of after the effective date. Early adoption is permitted, but only for disposals (or classifications as held for sale) that have not been reported in financial statements previously issued. The effects of ASU 2014-08 will depend on any future disposals by the Company.

In July 2013, the FASB issued ASU No. 2013-11, Presentation of an Unrecognized Tax Benefit when a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists. This standard requires an entity to present unrecognized tax benefits as a reduction to deferred tax assets when a net operating

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loss carryforward, similar tax loss or a tax credit carryforward exists, with limited exceptions. This standard is effective for fiscal years beginning on or after December 15, 2013, and for interim periods within those fiscal years. The Company has adopted this guidance in fiscal 2014 and the adoption of this new guidance did not have a material impact on the Company s consolidated financial statements.

**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. The Company has expensed an aggregate of $689, $1,004, and $1,092 to these law firms in the fiscal years ended June 30, 2014, 2013 and 2012, respectively. Included in the Company s consolidated balance sheets at June 30, 2014 and 2013 is $115 and $216, respectively, of amounts payable to these law firms.

**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.***

**Disclosure Controls and Procedures** We maintain controls and procedures designed to ensure that we are able to collect the information we are required to disclose in the reports we file with the SEC, and to process, summarize and disclose this information within the time periods specified in the rules of the SEC.

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities and Exchange Act of 1934 as amended (the Exchange Act )) as of the end of the period covered by this report. Based on such evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that, as of the end of such period, our disclosure controls and procedures are effective.

**Changes in Internal Controls over Financial Reporting** There were no changes to our internal control over financial reporting during the year ended June 30, 2014 that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

**Section 404(b)** Section 404(a) of the Sarbanes-Oxley Act of 2002 (SOX) requires annual reports on Form 10-K to contain a report from management on the effectiveness of an issuer s internal control over financial reporting. Separately, Section 404(b) generally requires an issuer s regular auditor to attest to and report on management s assessment. However, Section 989G of the Dodd-Frank Wall Street Reform and Consumer Protection Act permanently exempted non-accelerated filers, including smaller reporting companies from the requirements of Section 404(b). Accordingly, this annual report does not include any attestation and report from SunLink s independent registered public accounting firm with respect to the effectiveness of the Company s internal controls over financial reporting.

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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.

Report of Independent Registered Public Accounting Firm.

Consolidated Balance Sheets June 30, 2014 and 2013.

Consolidated Statements of Operations and Comprehensive Earnings and Loss For the Years Ended June 30, 2014, 2013 and 2012.

Consolidated Statements of Shareholders Equity For the Years Ended June 30, 2014, 2013 and 2012.

Consolidated Statements of Cash Flows For the Years Ended June 30, 2014, 2013 and 2012.

Notes to Consolidated Financial Statements For the Years Ended June 30, 2014, 2013 and 2012.

(a) (2) Financial Statement Schedules



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 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:

| | |
|---|---|
| 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) |
| 3.1a | Amended Articles of Incorporation of KRUG International Corp. (incorporated by reference to Exhibit 3.1 of the Corporation s Report on Form 10-K405 for the year ended March 31, 1998). (Commission File No. 98649171) |
| 3.1b | Amended Articles of Incorporation of SunLink Health Systems, Inc. (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) |
| 3.1c | 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) |
| 3.2 | Code of Regulations of SunLink Health Systems, Inc., as amended (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) |

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| 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) |
| 4.1 | Shareholder Rights Agreement dated as of February 10, 2014, between SunLink Health Systems, Inc. and American Stock Transfer & Trust Company, LLC, as Rights Agent (incorporated by reference from Exhibit 4.1 of the Company s Report on Form 8-K filed February 27, 2014). (Commission File No. 14647348) |
| 10.1* | 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) |
| 10.2* | 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) |
| 10.3 | 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) |
| 10.4* | 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) |
| 10.5 | 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) |
| 10.6 | 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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| 10.8 | 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) |
| 10.9 | 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) |
| 10.10 | 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) |
| 10.11* | 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) |
| 10.12 | Loan Agreement dated as of March 19, 2012 by and among Pioneer Bank, SSB; HealthMont of Missouri, LLC; HealthMont, LLC; and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 10.1 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |
| 10.13 | Promissory Note in the amount of $4,000,000 dated as of March 19, 2012 from Healthmont of Missouri, LLC payable to Pioneer Bank, S.S.B. (incorporated by reference from Exhibit 10.2 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |
| 10.14 | Promissory Note in the amount of $1,000,000 dated as of March 19, 2012 from Healthmont of Missouri, LLC payable to Pioneer Bank, S.S.B. (incorporated by reference from Exhibit 10.3 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |

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|---|---|
| 10.15 | Fourth 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 March 19, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.16 | Fifth 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 May 3, 2012. (incorporated by reference from Exhibit 99.3 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.17 | Sixth 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 May 4, 2012. (incorporated by reference from Exhibit 99.4 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.18 | Seventh Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 June 29, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K filed July 13, 2012). (Commission File No. 12961359) |
| 10.19 | Eighth Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 5, 2012. (incorporated by reference from Exhibit 99.3 to Current Report on Form 8-K filed July 13, 2012). (Commission File No. 12961359) |
| 10.20 | Asset Purchase Agreement By and Among HealthMont of Georgia, Inc., SunLink Health Systems, Inc. and Hospital Authority of Tift County, Georgia as of March 1, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K/A filed July 5, 2012). (Commission File No. 12961359) |

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| 10.21 | Mortgage Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676) |
| 10.22 | Working Capital Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676) |
| 10.23 | Ninth Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 October 31, 2012. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012). (Commission File No. 121203717) |
| 10.24 | Loan Agreement dated as of October 31, 2012 by and among Pioneer Bank, SSB; SunLink Healthcare Professional Property, LLC; MedCare South, LLC; and SunLink Health Systems, Inc. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012). (Commission File No. 121203717) |
| 10.25 | Amendment and Waiver to Mortgage Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205) |
| 10.26 | Amendment and Waiver to Working Capital Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205) |
| 10.27 | Second Amendment and Waiver to Mortgage Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753) |
| 10.28 | Second Amendment and Waiver to Working Capital Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753) |
| 10.29 | Third Amendment and Waiver to Mortgage Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. ^ |
| 10.30 | Third Amendment and Waiver to Working Capital Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. ^ |
| 10.31* | 2011 Director Stock Option Plan (incorporated by reference from Appendix A to the Company s Schedule 14A Definitive Proxy Statement filed September 29, 2011) (Commission File No. 111115265). |
| 21.1 | List of Subsidiaries ^ |

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|---|---|
| 23.1 | Consent of Cherry Bekaert LLP ^ |
| 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.^ |
| 101 | The following materials from the Company s Year End Report on Form 10-K for the fiscal year ended June 30, 2014, formatted in eXtensible Business Reporting Language ( XBRL ): (i) Consolidated Balance Sheets as of June 30, 2014 and June 30, 2013, (ii) Consolidated Statements of Operations and Comprehensive Earnings and Loss for the fiscal years ended June 30, 2014, 2013 and 2012, (iii) Consolidated Statements of Shareholders Equity for the fiscal years ended June 30, 2014, 2013 and 2012 (iv) Consolidated Statements of Cash Flows for the fiscal years ended June 30, 2014, 2013 and 2012, and (v) Notes to Consolidated Financial Statements. |

* 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 26th day of September, 2014.**

SUNLINK HEALTH SYSTEMS, INC.

By: /s/ ROBERT M. THORNTON, JR.
**Robert M. Thornton, Jr.**

**Chairman and Chief Executive Officer**

**Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of SunLink Health Systems, Inc. and in the capacities and on the dates indicated:**

| Name | Title | Date |
|---|---|---|
| /s/ ROBERT M. THORNTON, JR.<br>**Robert M. Thornton, Jr.** | Director, Chairman, President and Chief Executive Officer (principal executive officer) | September 26, 2014 |
| /s/ MARK J. STOCKSLAGER<br>**Mark J. Stockslager** | Chief Financial Officer and Principal Accounting Officer (principal accounting officer) | September 26, 2014 |
| /s/ STEVEN J. BAILEYS, D.D.S.<br>**Steven J. Baileys, D.D.S.** | Director | September 26, 2014 |
| /s/ KAREN B. BRENNER<br>**Karen B. Brenner** | Director | September 26, 2014 |
| /s/ GENE E. BURLESON<br>**Gene E. Burleson** | Director | September 26, 2014 |
| /s/ C. MICHAEL FORD<br>**C. Michael Ford** | Director | September 26, 2014 |
| /s/ CHRISTOPHER H. B. MILLS<br>**Christopher H. B. Mills** | Director | September 26, 2014 |
| /s/ HOWARD E. TURNER<br>**Howard E. Turner** | Director | September 26, 2014 |

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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, 2014 and 2013 and for each of the years in the three-year period ended June 30, 2014 and have issued our report thereon dated September 26, 2014; such consolidated financial statements and report are included elsewhere in this Form 10-K. 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, 2014. 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 LLP

Atlanta, Georgia

September 26, 2014

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**SUNLINK HEALTH SYSTEMS, INC. AND SUBSIDIARIES**

**SCHEDULE II VALUATION AND QUALIFYING ACCOUNTS**

**(amounts in thousands)**

| Column A<br>Allowance for Doubtful Accounts | Column B<br>Balance at Beginning Of Year | Column C<br>Charged to Cost and Expenses | Column C<br>Currency Translation/ Acquisition/ (Disposition) | Column D<br>Deductions from Reserves | Column E<br>Balance at End of Year |
|---|---|---|---|---|---|
| Year Ended June 30, 2014 | $ 7,761 | $ 11,319 | $ | $ (12,177) | $ 6,903 |
| Year Ended June 30, 2013 | $ 9,121 | $ 13,982 | $ (1,615) | $ (13,727) | $ 7,761 |
| Year Ended June 30, 2012 | $ 12,317 | $ 17,410 | $ (6,725) | $ (13,881) | $ 9,121 |

| 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, 2014 | $ 2,151 | $ 426 | $ | $ | $ 2,577 |
| Year Ended June 30, 2013 | $ 2,045 | $ 106 | $ | $ | $ 2,151 |
| Year Ended June 30, 2012 | $ 2,078 | $ 123 | $ | $ (156) | $ 2,045 |

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**INDEX TO EXHIBITS**

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| 3.1a | Amended Articles of Incorporation of KRUG International Corp. (incorporated by reference to Exhibit 3.1 of the Corporation s Report on Form 10-K405 for the year ended March 31, 1998). (Commission File No. 98649171) |
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| 3.2 | Code of Regulations of SunLink Health Systems, Inc., as amended (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) |
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| 10.4* | 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) |
| 10.5 | 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) |

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| 10.8 | 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) |
| 10.9 | 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) |
| 10.10 | 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) |
| 10.11* | 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) |
| 10.12 | Loan Agreement dated as of March 19, 2012 by and among Pioneer Bank, SSB; HealthMont of Missouri, LLC; HealthMont, LLC; and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 10.1 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |
| 10.13 | Promissory Note in the amount of $4,000,000 dated as of March 19, 2012 from Healthmont of Missouri, LLC payable to Pioneer Bank, S.S.B. (incorporated by reference from Exhibit 10.2 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |

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|---|---|
| 10.14 | Promissory Note in the amount of $1,000,000 dated as of March 19, 2012 from Healthmont of Missouri, LLC payable to Pioneer Bank, S.S.B. (incorporated by reference from Exhibit 10.3 to Current Report on Form 8-K filed March 29, 2012). (Commission File No. 12725101) |
| 10.15 | Fourth 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 March 19, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.16 | Fifth 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 May 3, 2012. (incorporated by reference from Exhibit 99.3 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.17 | Sixth 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 May 4, 2012. (incorporated by reference from Exhibit 99.4 to Current Report on Form 8-K filed May 8, 2012). (Commission File No. 12823311) |
| 10.18 | Seventh Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 June 29, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K filed July 13, 2012). (Commission File No. 12961359) |
| 10.19 | Eighth Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 5, 2012. (incorporated by reference from Exhibit 99.3 to Current Report on Form 8-K filed July 13, 2012). (Commission File No. 12961359) |

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|---|---|
| 10.20 | Asset Purchase Agreement By and Among HealthMont of Georgia, Inc., SunLink Health Systems, Inc. and Hospital Authority of Tift County, Georgia as of March 1, 2012. (incorporated by reference from Exhibit 99.2 to Current Report on Form 8-K/A filed July 5, 2012). (Commission File No. 12961359) |
| 10.21 | Mortgage Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676) |
| 10.22 | Working Capital Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676) |
| 10.23 | Ninth Modification to Loan Documents between SunLink Health Systems, Inc., SunLink Healthcare LLC, Dexter 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 October 31, 2012. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012). (Commission File No. 121203717) |
| 10.24 | Loan Agreement dated as of October 31, 2012 by and among Pioneer Bank, SSB; SunLink Healthcare Professional Property, LLC; MedCare South, LLC; and SunLink Health Systems, Inc. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended September 30, 2012). (Commission File No. 121203717) |
| 10.25 | Amendment and Waiver to Mortgage Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205) |
| 10.26 | Amendment and Waiver to Working Capital Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205) |
| 10.27 | Second Amendment and Waiver to Mortgage Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753) |
| 10.28 | Second Amendment and Waiver to Working Capital Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company s Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753) |
| 10.29 | Third Amendment and Waiver to Mortgage Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. ^ |
| 10.30 | Third Amendment and Waiver to Working Capital Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. ^ |

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|---|---|
| 10.31* | 2011 Director Stock Option Plan (incorporated by reference from Appendix A to the Company s Schedule 14A Definitive Proxy Statement filed September 29, 2011) (Commission File No. 111115265). |
| 21.1 | List of Subsidiaries ^ |
| 23.1 | Consent of Cherry Bekaert LLP ^ |
| 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.^ |
| 101 | The following materials from the Company s Year End Report on Form 10-K for the fiscal year ended June 30, 2014, formatted in eXtensible Business Reporting Language ( XBRL ): (i) Consolidated Balance Sheets as of June 30, 2014 and June 30, 2013, (ii) Consolidated Statements of Operations and Comprehensive Earnings and Loss for the fiscal years ended June 30, 2014, 2013 and 2012, (iii) Consolidated Statements of Shareholders Equity for the fiscal years ended June 30, 2014, 2013 and 2012 (iv) Consolidated Statements of Cash Flows for the fiscal years ended June 30, 2014, 2013 and 2012, and (v) Notes to Consolidated Financial Statements. |

* 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, 2014 and 2013 and the related consolidated statements of operations and comprehensive earnings and loss, shareholders equity, and cash flows for each of the years in the three-year period ended June 30, 2014. 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, 2014 and 2013, and the consolidated results of its operations and its cash flows for each of the years in the three-year period ended June 30, 2014, in conformity with accounting principles generally accepted in the United States of America.

/s/Cherry Bekaert LLP

Atlanta, Georgia

September 26, 2014

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**SUNLINK HEALTH SYSTEMS, INC.**

**CONSOLIDATED BALANCE SHEETS**

**JUNE 30, 2014 AND 2013**

**(All Amounts in thousands)**

| | 2014 | 2013 |
|---|---|---|
| **ASSETS** | | |
| CURRENT ASSETS: | | |
| Cash and cash equivalents | $ 3,587 | $ 2,497 |
| Cash in escrow | 0 | 160 |
| Receivables net | 9,850 | 12,356 |
| Inventory | 4,009 | 3,798 |
| Income tax receivable | 0 | 1,769 |
| Deferred income tax asset | 2,978 | 4,008 |
| Prepaid expenses and other assets | 2,565 | 3,505 |
| Due from third party payors | 2,786 | 0 |
| Total current assets | 25,775 | 28,093 |
| PROPERTY, PLANT AND EQUIPMENT | | |
| Land | 1,992 | 1,992 |
| Buildings and improvements | 29,826 | 29,452 |
| Equipment and fixtures | 33,603 | 33,396 |
| | 65,421 | 64,840 |
| Less accumulated depreciation | 36,702 | 34,266 |
| Property, plant and equipment net | 28,719 | 30,574 |
| NONCURRENT ASSETS: | | |
| Intangible assets net | 3,031 | 3,175 |
| Goodwill | 461 | 461 |
| Deferred income tax asset | 4,432 | 4,113 |
| Other noncurrent assets | 1,429 | 1,587 |
| Total noncurrent assets | 9,353 | 9,336 |
| TOTAL ASSETS | $ 63,847 | $ 68,003 |
| **LIABILITIES AND SHAREHOLDERS EQUITY** | | |
| CURRENT LIABILITIES: | | |
| Accounts payable | $ 4,530 | $ 5,474 |
| Current maturities of long-term debt | 5,378 | 9,542 |
| Accrued payroll and related taxes | 4,186 | 4,121 |
| Due to third party payors | 0 | 556 |
| Deferred gain Medicare Electronic Health Records incentives | 0 | 1,136 |
| Income tax payable | 73 | 0 |
| Other accrued expenses | 2,314 | 1,417 |
| Total current liabilities | 16,481 | 22,246 |

| | | |
|---|---|---|
| LONG-TERM LIABILITIES: | | |
| Long-term debt | 11,973 | 8,728 |
| Noncurrent liability for professional liability risks | 1,268 | 2,461 |
| Other noncurrent liabilities | 807 | 825 |
| Total long-term liabilities | 14,048 | 12,014 |
| COMMITMENTS AND CONTINGENCIES | | |
| SHAREHOLDERS EQUITY: | | |
| Preferred Shares, authorized and unissued, 2,000 shares | 0 | 0 |
| Common Shares, no par value; authorized, 12,000 shares; issued and outstanding, 9,444 shares at June 30, 2014 and 9,444 shares at June 30, 2013 | 4,722 | 4,722 |
| Additional paid-in capital | 13,444 | 13,396 |
| Retained earnings | 15,486 | 16,031 |
| Accumulated other comprehensive loss | (334) | (406) |
| Total Shareholders Equity | 33,318 | 33,743 |
| TOTAL LIABILITIES AND SHAREHOLDERS EQUITY | $ 63,847 | $ 68,003 |

See notes to consolidated financial statements.

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**SUNLINK HEALTH SYSTEMS, INC.**

**CONSOLIDATED STATEMENTS OF OPERATIONS**

**AND COMPREHENSIVE EARNINGS AND LOSS**

**FOR THE YEARS ENDED JUNE 30, 2014, 2013 AND 2012**

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

| | Years Ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Operating revenues (net of contractual allowances) | $ 116,495 | $ 120,078 | $ 123,269 |
| Less provision for bad debts of Healthcare Facilities Segment | 11,065 | 11,770 | 10,053 |
| Net Revenues | 105,430 | 108,308 | 113,216 |
| Costs and expenses: | | | |
| Cost of goods sold | 22,110 | 22,363 | 26,073 |
| Salaries, wages and benefits | 51,096 | 52,660 | 52,115 |
| Provision for bad debts of Specialty Pharmacy Segment and Other | 254 | 597 | 632 |
| Supplies | 8,605 | 9,095 | 8,428 |
| Purchased services | 7,183 | 7,480 | 7,958 |
| Other operating expenses | 14,696 | 15,400 | 15,661 |
| Rents and leases expense | 1,775 | 1,918 | 2,191 |
| Impairment of property, plant and equipment | 0 | 789 | 0 |
| Impairment of goodwill and intangible assets | 0 | 0 | 931 |
| Depreciation and amortization | 3,662 | 4,048 | 4,365 |
| Electronic Health Records incentive payments | (3,911) | (4,947) | (7,294) |
| Operating profit (loss) | (40) | (1,095) | 2,156 |
| Other income (expense): | | | |
| Interest expense | (1,220) | (1,796) | (4,377) |
| Loss on sale of assets | (43) | 0 | (20) |
| Loss from continuing operations before income taxes | (1,303) | (2,891) | (2,241) |
| Income tax (benefit) expense | 88 | (1,306) | (565) |
| Loss from continuing operations | (1,391) | (1,585) | (1,676) |
| Earnings from discontinued operations, net of income taxes | 846 | 6,073 | 2,757 |
| Net earnings (loss) | (545) | 4,488 | 1,081 |
| Other comprehensive income (loss) | 72 | 91 | (219) |
| Comprehensive income (loss) | $ (473) | $ 4,579 | $ 862 |
| Earnings (loss) per share: | | | |
| Continuing operations: | | | |
| Basic | $ (0.15) | $ (0.17) | $ (0.18) |
| Diluted | $ (0.15) | $ (0.17) | $ (0.18) |

| | | | |
|---|---|---|---|
| Discontinued operations: | | | |
| Basic | $ 0.09 | $ 0.64 | $ 0.29 |
| Diluted | $ 0.09 | $ 0.64 | $ 0.29 |
| Net earnings (loss): | | | |
| Basic | $ (0.06) | $ 0.48 | $ 0.12 |
| Diluted | $ (0.06) | $ 0.48 | $ 0.12 |
| Weighted-average common shares outstanding: | | | |
| Basic | 9,443 | 9,445 | 9,350 |
| Diluted | 9,443 | 9,445 | 9,350 |

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, 2014, 2013 AND 2012**

**(All amounts in thousands)**

| | Common Shares | | Additional Paid-in | | Accumulated Other Comprehensive | | Total Shareholders |
|---|---|---|---|---|---|---|---|
| | Shares | Amount | Capital | Retained Earnings | Earnings (Loss) | Noncontrolling Interest | Equity |
| JUNE 30, 2011 | 8,120 | $ 4,060 | $ 11,751 | $ 10,462 | $ (278) | $ 73 | $ 26,068 |
| Net earnings | 0 | 0 | 0 | 1,081 | 0 | 0 | 1,081 |
| Minimum pension liability adjustment, net of tax of $133 | 0 | 0 | 0 | 0 | (219) | 0 | (219) |
| Share-based compensation | 0 | 0 | 92 | 0 | 0 | 0 | 92 |
| Common shares issued | 1,328 | 664 | 1,678 | 0 | 0 | 0 | 2,342 |
| Change in noncontrolling interest | 0 | 0 | 0 | 0 | 0 | (73) | (73) |
| JUNE 30, 2012 | 9,448 | 4,724 | 13,521 | 11,543 | (497) | 0 | 29,291 |
| Net earnings | 0 | 0 | 0 | 4,488 | 0 | 0 | 4,488 |
| Minimum pension liability adjustment, net of tax of $55 | 0 | 0 | 0 | 0 | 91 | 0 | 91 |
| Share-based compensation | 0 | 0 | 86 | 0 | 0 | 0 | 86 |
| Common shares issued (repurchased) | (4) | (2) | (211) | 0 | 0 | 0 | (213) |
| JUNE 30, 2013 | 9,444 | 4,722 | 13,396 | 16,031 | (406) | 0 | 33,743 |
| Net loss | 0 | 0 | 0 | (545) | 0 | 0 | (545) |
| Minimum pension liability adjustment, net of tax of $44 | 0 | 0 | 0 | 0 | 72 | 0 | 72 |
| Share-based compensation | 0 | 0 | 48 | 0 | 0 | 0 | 48 |
| JUNE 30, 2014 | 9,444 | $ 4,722 | $ 13,444 | $ 15,486 | $ (334) | $ 0 | $ 33,318 |

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, 2014, 2013 AND 2012**

**(All amounts in thousands)**

| | Years Ended June 30, | | |
|---|---|---|---|
| | **2014** | **2013** | **2012** |
| CASH FLOWS FROM OPERATING ACTIVITIES | | | |
| Net earnings (loss) | $ (545) | $ 4,488 | $ 1,081 |
| Adjustments to reconcile net earnings (loss) to net cash provided by (used in) operating activities: | | | |
| Depreciation and amortization | 3,662 | 4,048 | 4,365 |
| Share-based compensation | 48 | 86 | 92 |
| Impairment of goodwill and intangible assets | 0 | 0 | 931 |
| Impairment of property, plant and equipment | 0 | 789 | 0 |
| Loss on disposal of property, plant and equipment | 43 | 0 | 20 |
| Gain on sale of Dexter Hospital | 0 | (9,289) | 0 |
| Gain on sale of Memorial Hospital of Adel | 0 | (1,161) | 0 |
| Change in assets and liabilities: | | | |
| Receivables | 2,505 | 873 | 3,000 |
| Inventory | (211) | 86 | 204 |
| Prepaid expenses and other assets | 1,487 | (153) | (352) |
| Accounts payable and accrued expenses | (1,128) | (3,794) | (1,833) |
| Income taxes | 1,842 | (1,571) | 1,328 |
| Deferred income taxes | 803 | 2,944 | 568 |
| Third-party payor settlements | (3,342) | 1,032 | 33 |
| Electronic Health Records deferred gain | (1,135) | 1,135 | (8,348) |
| Net activities of discontinued operations | (137) | (1,529) | 1,993 |
| Net cash provided by (used in) operating activities | 3,892 | (2,016) | 3,082 |
| CASH FLOWS FROM INVESTING ACTIVITIES | | | |
| Proceeds from sale of Memorial Hospital of Adel | 0 | 8,350 | 0 |
| Proceeds from sale of Dexter Hospital | 0 | 9,930 | 0 |
| Change in cash in escrow | (160) | 160 | 0 |
| Expenditures for property, plant and equipment continuing operations | (1,723) | (4,975) | (1,518) |
| Expenditures for property, plant and equipment discontinued operations | 0 | (45) | (496) |
| Net cash (used in) provided by investing activities | (1,883) | 13,420 | (2,014) |
| CASH FLOWS FROM FINANCING ACTIVITIES: | | | |
| Payment of long-term debt | (919) | (17,519) | (13,622) |
| Proceeds from long-term debt | 0 | 12,699 | 4,388 |
| Revolving advances, net | 0 | (5,931) | 631 |
| Repurchase of common shares | 0 | (213) | 0 |
| Proceeds from issuance of common shares | 0 | 0 | 2,342 |
| Net cash used in by financing activities | (919) | (10,964) | (6,261) |
| NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS | 1,090 | 440 | (5,193) |
| CASH AND CASH EQUIVALENTS: | | | |
| Beginning of year | 2,497 | 2,057 | 7,250 |

| | | | |
|---|---|---|---|
| End of year | $ 3,587 | $ 2,497 | $ 2,057 |
| | | | |
| SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION | | | |
| Cash paid for: | | | |
| Income taxes | $ (1,881) | $ 2,116 | $ (1,242) |
| | | | |
| Interest | $ 1,128 | $ 1,752 | $ 4,029 |
| | | | |
| Non-cash investing and financing activities: | | | |
| Assets acquired under capital lease obligation continuing operations | $ 0 | $ 0 | $ 80 |
| | | | |
| Assets acquired under capital lease obligation discontinued operations | $ 0 | $ 0 | $ 349 |
| | | | |
| Long-term debt issued as payment-in-kind for interest payable | $ 0 | $ 0 | $ 105 |

See notes to consolidated financial statements.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

**AS OF AND FOR THE YEARS ENDED JUNE 30, 2014, 2013 AND 2012**

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

## 1. BUSINESS OPERATIONS

SunLink Health Systems, Inc. through subsidiaries ( SunLink , we , our , ours , us or the Company ), owns businesses which are prov healthcare services in certain markets in the United States. SunLink s business is composed of the ownership of two business segments:

The Healthcare Facilities Segments is composed of three operational areas:

- Four community hospital subsidiaries in three states with a total of 232 licensed beds;
- Two nursing homes with a total of 166 licensed beds, each of which is located adjacent to, or in close proximity with a corresponding SunLink community hospital; and
- A Clanton, Alabama healthcare facility which is currently vacant except for two offices rented to a physician and a testing lab.

The Specialty Pharmacy Segment is composed of four operational areas:

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

SunLink subsidiaries have conducted the healthcare facilities business since 2001 and the 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.

## 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

***Principles of Consolidation*** The consolidated financial statements include the accounts of SunLink and its subsidiaries, all of which are 100% 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 s subsidiaries have 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

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

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, 2014, there were no material claims or disputes with third-party payors.

***Charity Care*** SunLink s subsidiaries hospitals provide care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because SunLink subsidiaries do not pursue collection of amounts determined to qualify as charity, they are not reported as revenue. SunLink s subsidiaries hospitals provided $8,822, $9,615, and $9,566, of charity care in the fiscal years ended June 30, 2014, 2013 and 2012, respectively.

***Concentrations of Credit Risk*** SunLink subsidiaries grant unsecured credit to their patients, most of who reside in the service area of the subsidiaries facilities and are insured under third-party agreements. Although SunLink s two Georgia facilities generated approximately 51%, 53%, and 51% of gross revenues for the years ended June 30, 2014, 2013 and 2012, 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%, 40%, and 37% of net revenues for the years ended June 30, 2014, 2013 and 2012, respectively. For SunLink s Healthcare Facilities Segment, Medicaid was approximately 21%, 20%, and 22% of net revenues for the years ended June 30, 2014, 2013 and 2012, respectively. For SunLink s Healthcare Facilities Segment, Medicare receivables were approximately 47% and 44% of receivables net at June 30, 2014 and 2013, respectively, while Medicaid receivables were approximately 12% and 15% of receivables net at June 30, 2014 and 2013, 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.

***Allowance for Doubtful Accounts*** Substantially all of SunLink s subsidiaries 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 the Healthcare Facilities Segment, an allowance percentage is calculated 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 the Specialty Pharmacy Segment operations, an allowance percentage is calculated 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.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

***Medicare and Medicaid Electronic Health Records ( EHR ) Incentives*** The Company accounts for EHR incentive payments in accordance with Accounting Standards Codification 450-30, Gain Contingencies , ( 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, is 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 of the asset, whichever is shorter, and range from 5 to 15 years. For the 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 $3,520, $3,903, and $4,207, for the years ended June 30, 2014, 2013 and 2012, respectively.

***Risk Management*** SunLink and its subsidiaries are 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.

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 of a business. These amounts are based on actuarially determined estimates.

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**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

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 and its subsidiaries, if any, estimates are revised as additional facts become known.

***Long-lived Assets*** SunLink and its subsidiaries 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 and its subsidiaries evaluate 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 $48, $86 and $92 for the fiscal years ended June 30, 2014, 2013 and 2012, 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 long-term debt is estimated to approximate the recorded value due to its current variable interest rate.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

***Fair Value Measurements*** Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the U.S. Generally Accepted Accounting Principles ( GAAP ) fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity s own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

*Level 1:* Quoted market prices in active markets for identical assets or liabilities.

*Level 2:* Observable market-based inputs or unobservable inputs that are corroborated by market data.

*Level 3:* Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company s own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company s assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

***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, the 2005 Equity Incentive Plan, and the 2011 Director Stock Option Plan. Common share equivalents represent the dilutive effect of the assumed exercise of the outstanding stock options.

***Recent Accounting Pronouncements*** In August 2014, the Financial Accounting Standards Board ( FASB ) issued Accounting Standards Update ( ASU ) 2014-15 Disclosure of Uncertainties about an Entity s Ability to Continue as a Going Concern ( ASU 2014-15 ). ASU 2014-15 wil explicitly require management to assess an entity s ability to continue as a going concern, and to provide related footnote disclosure in certain circumstances. The new standard will be effective for all entities in the first annual period ending after December 15, 2016. Earlier adoption is permitted. We are currently evaluating the impact of the adoption of ASU 2014-15.

In April 2014, the FASB issued ASU 2014-08, Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity, ( ASU 2014-08 ). Under ASU 2014-08, only disposals representing a strategic shift in operations that have a major effect on the Company s operations and financial results should be presented as discontinued operations. Additionally, ASU 2014-08 requires expanded disclosures about discontinued operations that will provide financial statement users with more information about the assets, liabilities, income, and expenses of discontinued operations. The amendments in ASU 2014-08 are effective for fiscal years, and interim periods within those years, beginning after December 15, 2014. However, ASU 2014-08 should not be applied to a component that is classified as held for sale before the effective date even if the component is disposed of after the effective date. Early adoption is permitted, but only for disposals (or classifications as held for sale) that have not been reported in financial statements previously issued. The effects of ASU 2014-08 will depend on any future disposals by the Company.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

In July 2013, the FASB issued ASU No. 2013-11, Presentation of an Unrecognized Tax Benefit when a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists. This standard requires an entity to present unrecognized tax benefits as a reduction to deferred tax assets when a net operating loss carryforward, similar tax loss or a tax credit carryforward exists, with limited exceptions. This standard is effective for fiscal years beginning on or after December 15, 2013, and for interim periods within those fiscal years. The Company has adopted this guidance in fiscal 2014 and the adoption of this new guidance did not have a material impact on the Company s consolidated financial statements.

**3. 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.

***Dexter Hospital*** On December 31, 2012, the Company completed the sale of substantially all the assets and the leasehold interest of its subsidiary, Dexter Hospital, LLC ( Dexter ), to Southeast Health Center of Stoddard County, LLC, an indirect subsidiary of Southeast Missouri Hospital Association ( SoutheastHEALTH ). The assets of Dexter consisted of a leased 50-bed acute care hospital and related clinics, equipment, and home health services in Dexter, Missouri. Subsequent to the sale, Dexter has managed the hospital and related businesses for Southeast Health Center of Stoddard County, LLC and have done so through a transition period that ended June 30, 2013. Dexter retained accounts receivable and certain other assets, including the right to Medicare and Medicaid incentive payments ( EHR Funds ) for meaningful use of electronic health record technology and substantially all liabilities of the hospital as of December 31, 2012. The sale of the assets, including the right to EHR Funds, and leasehold interest of Dexter for approximately $9,930, less sale expenses and taxes, resulted in net proceeds of approximately $7,400. Approximately $5,200 of the net proceeds was used to pay off the outstanding balance of the Company s senior credit facility under the Term Loan of the Company s then outstanding Credit Facility. Dexter s operations have been reclassified as discontinued operations in our consolidated financial statements for the fiscal years ended June 30, 2014, 2013 and 2012.

***Memorial Hospital of Adel*** On July 2, 2012, the Company and its HealthMont of Georgia, Inc. subsidiary completed the sale of substantially of all the assets of Memorial Hospital of Adel and Memorial Convalescent Center (collectively Memorial ) to the Hospital of Authority of Tift County, Georgia ( Tift ) for approximately $8,350. The net proceeds from the sale of approximately $7,500 were used to repay a portion of the Company s senior debt under the Term Loan under the Company s then outstanding Credit Facility. Memorial s operations have been reclassified as discontinued operations in our consolidated financial statements as of and for the fiscal years ended June 30, 2014, 2013 and 2012.

***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, 2014, 2013 and 2012.

***Discontinued Operations Reserves*** SunLink has discontinued operations carried on by its former life sciences and engineering segment as well as certain of our healthcare operations. SunLink s reserves related to discontinued operations of these segments represent management s best

estimate of SunLink and its subsidiaries possible liability for claims for which SunLink or its subsidiaries may incur liability. No reserve for discontinued operations is included in discontinued operations at June 30, 2014.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

Results for all the businesses included in discontinued operations are presented in the following table:

**Discontinued Operations Summary Statement of Earnings Information**

| | Years Ended June 30, | | |
|---|---|---|---|
| | **2014** | **2013** | **2012** |
| Net Revenues: | | | |
| Dexter Hospital | $ 602 | $ 9,634 | $ 20,066 |
| Memorial of Adel | (59) | 114 | 14,643 |
| | $ 543 | $ 9,748 | $ 34,709 |
| Earnings Before Income Taxes: | | | |
| Dexter Hospital | $ 1,548 | $ 542 | $ 3,751 |
| Memorial of Adel | (94) | (26) | 445 |
| Life sciences and engineering | (158) | (253) | (88) |
| Earnings before income taxes | 1,296 | 263 | 4,108 |
| Gain on Sale: | | | |
| Dexter Hospital | 0 | 9,289 | 0 |
| Memorial of Adel | 0 | 1,161 | 0 |
| Gain on Sale | 0 | 10,450 | 0 |
| Income tax expense | 450 | 4,640 | 1,351 |
| Earnings from discontinued operations | $ 846 | $ 6,073 | $ 2,757 |

**4. REVENUE RECOGNITION AND ACCOUNTS RECEIVABLES**

SunLink s subsidiaries have agreements with third-party payors that provide for payments at amounts different from the subsidiaries 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.

*Other* SunLink s subsidiaries have also 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.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

The Company s revenues before provision for doubtful accounts by payor were as follows for the years ended June 30, 2014, 2013 and 2012:

| | Years Ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Healthcare Facilities Segment: | | | |
| Medicare | $ 33,943 | $ 34,229 | $ 31,563 |
| Medicaid | 17,380 | 17,723 | 19,014 |
| Self-pay | 11,208 | 12,481 | 10,131 |
| Managed Care & Other Insurance | 19,798 | 21,435 | 23,635 |
| Other | 383 | 811 | 413 |
| Revenues before provision for doubtful accounts | 82,712 | 86,679 | 84,756 |
| Provision for doubtful accounts | (11,065) | (11,770) | (10,053) |
| Healthcare Facilities Segment Net Revenues | 71,647 | 74,909 | 74,703 |
| Specialty Pharmacy Segment Net Revenues | 33,322 | 33,314 | 38,099 |
| Other Revenues | 461 | 85 | 414 |
| Total Net Revenues | $ 105,430 | $ 108,308 | $ 113,216 |

The net revenues of the Specialty Pharmacy Segment are presented net of contractual adjustments. The provision for bad debts of the Specialty Pharmacy Segment is presented as a component of operating expenses in the Consolidated Statements of Operations and Comprehensive Earning and Loss. During the current year, the Company modified the approach to developing the data used to determine the revenue sources by payor in the Healthcare Facilities Segment. All prior year amounts have been changed to consistently apply the approach used in the current year. There was no impact on total segment revenues.

Summary information for receivables is as follows:

| | June 30, | |
|---|---|---|
| | 2014 | 2013 |
| Patient accounts receivable (net of contractual allowances) | $ 16,753 | $ 20,117 |
| Less allowance for doubtful accounts | (6,903) | (7,761) |
| Patient accounts receivable net | $ 9,850 | $ 12,356 |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

The following is a summary of the activity in the allowance for doubtful accounts for the Healthcare Facilities Segment and the Specialty Pharmacy Segment and Other for the fiscal years ended June 30, 2014 and 2013:

| | Healthcare Facilities | Specialty Pharmacy | Other | Total |
|---|---|---|---|---|
| **Fiscal year ended June 30, 2014** | | | | |
| Balance at July 1, 2013 | $ 7,286 | $ 475 | $ 0 | $ 7,761 |
| Additions recognized as a reduction to revenues | 11,065 | 0 | 0 | 11,065 |
| Bad debt expense | 0 | 254 | 0 | 254 |
| Accounts written off, net of recoveries | (11,702) | (475) | 0 | (12,177) |
| Balance at June 30, 2014 | $ 6,649 | $ 254 | $ 0 | $ 6,903 |

| | Healthcare Facilities | Specialty Pharmacy | Other | Total |
|---|---|---|---|---|
| **Fiscal year ended June 30, 2013** | | | | |
| Balance at July 1, 2012 | $ 8,714 | $ 407 | $ 0 | $ 9,121 |
| Additions recognized as a reduction to revenues | 11,770 | 0 | 0 | 11,770 |
| Bad debt expense | 0 | 514 | 83 | 597 |
| Accounts written off, net of recoveries | (13,198) | (446) | (83) | (13,727) |
| Balance at June 30, 2013 | $ 7,286 | $ 475 | $ 0 | $ 7,761 |

Net revenues included a decrease of $166 for the year ended June 30, 2013 for the settlement of filings of prior year Medicare and Medicaid cost reports. Net revenues included an increase of $214 and $547 for the years ended June 30, 2014 and 2012, respectively, for the settlements and filings of prior year Medicare and Medicaid cost reports.

**5. MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVES DEFERRED GAIN MEDICARE ELECTRONIC HEALTH RECORDS INCENTIVES**

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.

SunLink s four operating hospital subsidiaries successfully attested for the Medicare EHR program for the fiscal year ended June 30, 2014. Medicare EHR incentive payments for all four operating hospital subsidiaries totaling $2,494 were received during the quarter ended December 31, 2013 and recognized at June 30, 2014. In addition, $1,136 was received by Dexter (see Note 3. Discontinued Operations) for the fiscal year ended June 30, 2013. This Medicare EHR incentive payment was not recognized until June 30, 2014 as Medicare EHR incentive payments cannot be recognized until the cost report information utilized to determine the final amount of reimbursement is known. The amount recognized of $1,076 was less than the amount received due to an adjustment based on the December 31, 2013 cost report as filed by the buyer of Dexter. Based on revised

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**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

estimates using June 30, 2014 information, a third party receivable of $369 was recorded as of June 30, 2014 for SunLink s four operating hospitals. This amount will be collected upon final settlement of the cost reports for fiscal year 2014. Final settlement of cost reports for fiscal year 2013 resulted in an increase of $705 in Medicare EHR incentive payments recognized in continuing operations. This adjustment was recorded in fiscal year 2014.

SunLink s four operating hospitals and Dexter successfully attested for the Medicare EHR program for the fiscal year ended June 30, 2013. Incentive payments for all four operating hospital and Dexter totaling $5,257 were received by the hospitals during the quarter ended December 31, 2012. As Medicare EHR incentive payments cannot be recognized until the cost report information utilized to determine the final amount of reimbursement is known, SunLink recorded $1,136 as deferred gain as of June 30, 2013 for Dexter. This deferred gain was recognized in the quarter ended June 30, 2014, when information for the cost report period January 1, 2013 through December 31, 2013 was known (based on buyer s fiscal year). Based on revised estimates using June 30, 2014 information, a third party payable of $315 was recorded as of June 30, 2014 for SunLink s four operating hospitals and Dexter. This amount will be paid upon final settlement of cost reports for fiscal year 2013.

SunLink s four operating hospitals and Dexter, Memorial and Chilton (see Note 3. Discontinued Operations) successfully attested for the Medicare EHR program for the fiscal year ended June 30, 2012. Incentive payments for all four operating hospital and Dexter, Memorial and Chilton totaling $8,521 were received by SunLink during the quarter ended June 30, 2011. As Medicare EHR incentive payments cannot be recognized until the cost report information utilized to determine the final amount of reimbursement is known, SunLink recorded the $8,521 as deferred gain as of June 30, 2011. This deferred gain was recognized in the quarter ended June 30, 2012, when information for the cost report period July 1, 2011 through June 30, 2012 was known. Based on revised estimates using June 30, 2012 information, a receivable of $103 was recorded as of June 30, 2012. Final settlement of cost reports for fiscal year 2012 resulted in a decrease of $140 in Medicare EHR incentive payments recognized in continuing operations. This adjustment was recorded in fiscal year 2013.

SunLink s four operating hospital subsidiaries successfully attested for the Medicaid EHR program and recognized Medicaid EHR incentive payments in the fiscal year ended June 30, 2014. Medicaid EHR incentive reimbursement payments were received for SunLink s four operating hospitals during the fiscal year ended June 30, 2014 totaling $593. SunLink s four operating hospital subsidiaries and Dexter successfully attested for the Medicaid EHR program and recognized Medicaid EHR incentive payments in the fiscal year ended June 30, 2013. Medicaid EHR incentive reimbursement payments were received for SunLink s four operating hospitals and Dexter during the fiscal year ended June 30, 2013 totaling $1,320. SunLink s hospital in Mississippi successfully attested for the Medicaid EHR program in the quarter ended June 30, 2011. EHR incentive payments for SunLink s hospital in Mississippi were recognized in the fiscal year ended June 30, 2011 while payment was received in the fiscal year ended June 30, 2012. SunLink s Missouri hospital, its two Georgia hospitals, Dexter and Chilton successfully attested for the Medicaid EHR program for the federal attestation year ended September 30, 2011 and recognized Medicaid EHR incentive payments in the fiscal year ended June 30, 2012. Medicaid EHR incentive reimbursement payments were received for SunLink s four operating hospitals, Dexter and Chilton during the fiscal year ended June 30, 2012 totaling $2,357.

EHR incentive payments recognized in continuing operations for the years ending June 30, 2014, 2013 and 2012 are as follows:

| | 2014 | 2013 | 2012 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Medicare | $ 3,568 | $ 3,726 | $ 6,022 |
| Medicaid | 343 | 1,221 | 1,272 |
| | $ 3,911 | $ 4,947 | $ 7,294 |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

EHR incentive payments recognized in discontinued operations for the years ending June 30, 2014, 2013 and 2012 are as follows:

| | 2014 | 2013 | 2012 |
|---|---|---|---|
| Medicare | $ 1,076 | $ (89) | $ 2,602 |
| Medicaid | 0 | 248 | 809 |
| | $ 1,076 | $ 159 | $ 3,411 |

Medicare EHR incentive payments recognized in discontinued operations was a negative $89 for fiscal year 2013 due to final settlement of the 2012 cost reports.

## 6. INVENTORY

Inventory consisted of the following:

| | June 30, | |
|---|---|---|
| | 2014 | 2013 |
| Healthcare Facilities Segment Supplies Inventory | $ 1,726 | $ 1,743 |
| Specialty Pharmacy Segment Goods Held for Sale | 2,283 | 2,055 |
| | $ 4,009 | $ 3,798 |

## 7. IMPAIRMENT OF LONG-LIVED ASSETS

***Impairment of Long-Lived Assets*** A hospital facility and related equipment in Clanton, Alabama, formerly leased to a third party hospital operator is currently vacant with the exception of three leased offices. The net realizable value of the hospital and equipment was evaluated and it was determined that an impairment of the net value of the leased property, plant and equipment had occurred. An impairment charge of $789 was recognized during the first quarter of fiscal 2013.

***Impairment analysis*** For the purposes of these analyses, our estimates of fair value are based on a combination of the income approach, which estimates the fair value based on future discounted cash flows, and the market approach, which estimates the fair value of based on comparable market prices. Estimates of fair value for reporting units fall under Level 3 of the fair value hierarchy. Estimates of future discounted cash flows are based on assumptions and projections we believe to be currently reasonable and supportable. These assumptions take into account revenue

and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

During the third quarter of fiscal 2012, the Company performed an interim impairment testing of the goodwill and certain intangible assets of its subsidiaries as of March 31, 2012. The Company concluded that the carrying value of the subsidiary exceeded its fair value, and as a result, recognized a goodwill impairment charge of $931 for its Healthmont, LLC subsidiary, part of the Healthcare Facilities Segment, during the year ended June 30, 2012.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

## 8. GOODWILL AND INTANGIBLE ASSETS

SunLink s Specialty Pharmacy Segment has goodwill and intangible assets related to its Carmichael acquisition. SunLink s Healthcare Facilities Segment has intangible assets related to its Healthmont acquisition.

Goodwill consists of the following:

| | June 30, 2014 | 2013 |
|---|---|---|
| Specialty Pharmacy Segment | $ 461 | $ 461 |

Intangible assets consist of the following, net of amortization:

| | June 30, 2014 | June 30, 2013 |
|---|---|---|
| Healthcare Facilities Segment | | |
| Certificate of Need | $ 80 | $ 80 |
| Accumulated Amortization | (28) | (26) |
| | 52 | 54 |
| Specialty Pharmacy Segment | | |
| Trade Name | 2,000 | 2,000 |
| Customer Relationships | 1,089 | 1,089 |
| Medicare License | 769 | 769 |
| | 3,858 | 3,858 |
| Accumulated Amortization | (879) | (737) |
| | 2,979 | 3,121 |
| Total | $ 3,031 | $ 3,175 |

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

Amortization expense was $144, $145, and $157, for the fiscal years ended June 30, 2014, 2013 and 2012, respectively.

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

| | |
|---|---|
| 2015 | $ 145 |
| 2016 | 145 |
| 2017 | 145 |
| 2018 | 145 |
| 2019 | 145 |
| 2020 and thereafter | 306 |
| Total | $ 1,031 |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

## 9. LONG-TERM DEBT

Long-term debt consisted of the following:

| | June 30, 2014 | June 30, 2013 |
|---|---|---|
| Callaway RDA Loan | $ 4,801 | $ 4,908 |
| Trace RDA Loan | 8,624 | 9,047 |
| SHPP RDA Loan | 2,033 | 2,073 |
| Carmichael Notes | 1,852 | 2,152 |
| Capital lease obligations | 41 | 90 |
| Total | 17,351 | 18,270 |
| Less current maturities | (5,378) | (9,542) |
| | $ 11,973 | $ 8,728 |

***Callaway RDA Loan*** SunLink, HealthMont of Missouri, LLC ( HOM ) and HealthMont LLC ( HLLC ), the direct parent of HOM closed on a $5,000 Loan Agreement dated as of March 16, 2012 (the Callaway RDA Loan ) with a bank. HealthMont of Missouri, LLC owns and operates Callaway Community Hospital ( Callaway ) in Fulton, Missouri. The Loan Agreement consists of a $4,000 term loan and $1,000 construction loan. The $4,000 term loan was drawn in its entirety at closing and, as of June 30, 2014, the entirety of the $1,000 construction loan has been drawn. The Callaway RDA Loan is guaranteed by HLLC and the Company.

The Callaway RDA Loan has a term of 25 years with monthly payments of principal and interest. The Callaway RDA Loan bears a floating interest rate equal to the prime rate (as published in The Wall Street Journal) plus 2% (5.25% at June 30, 2014). The Callaway RDA Loan is collateralized by Callaway s real estate and equipment and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program. Of the Callaway RDA Loan proceeds, $3,250 was applied as payment against the Company s then outstanding Credit Facility. Approximately $1,000 of the Callaway RDA Loan proceeds were used to finance improvements, including to provide an inpatient geriatric psychiatry unit and an emergency department upgrade, with the remainder of the Callaway RDA Loan proceeds used for working capital and closing costs. Drawn but unused loan proceeds of $92 are included on the balance sheet at June 30, 2013 as cash in escrow.

The Callaway RDA Loan contains certain financial covenants with respect to the ratio of current assets to current liabilities and debt service coverage, all as defined in the Callaway RDA Loan Agreement and measured at the end of each fiscal year. At June 30, 2014, Callaway was not in compliance with the funded debt to EBITDA ratio. The Company is currently discussing a modification or waiver of this non-compliance with the lender but has been unable to obtain such waiver as of September 26, 2014. As a result, the amount of indebtedness under the Callaway RDA Loan of $4,801 is presented in current liabilities in the consolidated balance sheet as of June 30, 2014. If Callaway is unable to obtain a waiver of the non-compliance, the lender under the Callaway RDA Loan would, among other things, be entitled to call a default and demand repayment of the indebtedness outstanding from Callaway or from the Company under its guarantee of such indebtedness. The ability of Callaway and the Company to make the required debt service under the Callaway RDA Loan depends on, among other things, the ability of

Callaway and the Company to generate sufficient cash flows, including from operating activities. If Callaway or the Company are unable to generate sufficient cash flow from operations to meet debt service on the Callaway RDA loan or the guarantee, including in the event the lender were to declare an event of default and accelerate the maturity of the indebtedness, such failure could have material adverse effects on the Company. Although Callaway and the Company believe they will be able to negotiate a waiver, the Company cannot assure you that a waiver will be obtained or the timing thereof.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

***Trace RDA Loan and Trace Working Capital Loan*** On July 11, 2012, SunLink, Crown Healthcare Investments, LLC (formerly known as MedCare South, LLC) ( Crown ) and Southern Health Corporation of Houston, Inc. ( SHCH ), an indirect wholly-owned subsidiary of the Company, closed on a $9,975 Mortgage Loan Agreement dated as of July 5, 2012 ( Trace RDA Loan ) and up to a $1,000 Working Capital Loan Agreement dated as of July 5, 2012 ( Trace Working Capital Loan ) with a bank. The Trace Working Capital Loan was amended by the Third Amendment to Loan Agreement and Waiver effective June 30, 2014. SHCH owns and operates Trace Regional Hospital Trace ) in Houston, Mississippi. Both the Trace RDA Loan and the Trace Working Capital Loan are unconditionally guaranteed by the Company and Crown.

The Trace RDA Loan has a term of 15 years with monthly payments of principal and interest until repaid. The Trace RDA Loan bears a floating rate of interest equal to the greater of (i) the prime rate (as published in The Wall Street Journal) plus 1.5%, or (ii) 6% (6.0% at June 30, 2014). The Trace RDA Loan is collateralized by Trace s real estate and equipment and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program. Approximately $8,500 of the Trace RDA Loan proceeds was used to repay a portion of the Company s senior debt under the Term Loan under the then outstanding Credit Facility. Approximately $850 of the Trace RDA Loan proceeds were used for improvements to the hospital and its medical office building with the remainder of the loan proceeds used for working capital and closing costs. Drawn but unused loan proceeds of $68 are included on the balance sheet at June 30, 2013 as cash in escrow.

The Trace Working Capital Loan as amended provides for a revolving line of credit to SHCH equal to the lesser of (i) a Borrowing Base equal to eighty percent (80%) of Eligible Accounts Receivable (as defined in the Working Capital Loan Agreement dated July 5, 2012) or (ii) (a) prior to September 31, 2014, $1,000; (b) for the quarter ending December 31, 2014, $875; (c) for the quarter ended March 31, 2015, $750; (d) for the quarter ending June 30, 2014, $625; and (e) thereafter, $500. The Trace Working Capital Loan expires July 2, 2015. It is subject to annual renewal at the discretion of the lender. At June 30, 2014, there were no outstanding borrowings under the Trace Working Capital Loan.

The Trace RDA Loan contains various terms and conditions, including financial restrictions and limitations, and affirmative and negative covenants. The covenants include financial covenants measured on a quarterly basis which require our SHCH subsidiary to comply with a ratio of current assets to current liabilities, debt service coverage, fixed charge coverage, and funded debt to EBITDA, all as defined in the Trace RDA Loan. At March 31, 2014, SHCH was not in compliance with the debt to tangible net worth ratio. The Company received a waiver of this non-compliance from the lender effective June 30, 2014, and the Trace RDA Loan was amended effective June 30, 2014 by the Third Amendment to Loan Agreement and Waiver ( Third Amendment ). Under the Third Amendment, the funded debt to EBITDA ratio limits were modified Although SHCH and the Company believe they will be able to continue in compliance with the revised levels of financial covenants in the Trace RDA Loan, there is no assurance that SHCH and the Company will be able to do so.

***SHPP RDA Loan*** On November 6, 2012, SunLink Healthcare Professional Property, LLC, a subsidiary of the Company, entered into and closed on a $2,100 term loan dated as of October 31, 2012 (the SHPP RDA Loan ) with a bank. SHPP owns and leases a medical office building to Southern Health Corporation of Ellijay, Inc. ( SHC Ellijay ). SHC Ellijay owns and operates North Georgia Medical Center ( North Georgia ), located in Ellijay, Georgia. The SHPP RDA Loan is guaranteed by the Company and Crown.

The SHPP RDA Loan has a term of 25 years with monthly payments of principal and interest until repaid. The SHPP RDA Loan bears interest at a floating rate of interest equal to the greater of (i) the prime rate (as published in The Wall Street Journal) plus 2.0%, or (ii) 5% (5.25% at June 30, 2014). The SHPP RDA Loan is collateralized by SHPP s real estate, equipment and leases and is partially guaranteed under the U.S.

Department of Agriculture, Rural Development Business and Industry Program. Of the SHPP RDA Loan proceeds, $1,800

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

was used by SHC Ellijay to acquire a medical office building in Ellijay, Georgia which was then sold to SHPP, with the remainder of the SHPP RDA Loan proceeds used by SHPP for working capital and closing costs. The SHPP RDA Loan contains certain financial covenants with respect to the ratio of current assets to current liabilities and debt service coverage, all as defined in the SHPP RDA Loan Agreement, which SHPP must maintain and that are measured at the end of each fiscal year.

***Carmichael Notes*** On April 22, 2008, SunLink Scripts Rx, LLC entered into a $3,000 promissory note agreement with an interest rate of 8% with the former owners of Carmichael as part of the acquisition purchase price (the Carmichael Purchase Note ). On April 12, 2012, an amendment to the Carmichael Purchase Note was entered into under which SunLink has the option to issue 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 Purchase Note (the PIK Notes ). The PIK Notes bear an interest rate of 8% and were to be due on April 22, 2015. A PIK Note for $247 was issued on April 22, 2012 for the principal and interest payment that would have been due on April 22, 2012. A PIK Note for $252 was issued on October 22, 2012 for the principal and interest payment that would have been due on October 22, 2012. The Carmichael Purchase Note and the PIK Notes were combined into one note (the Carmichael Note dated April 22, 2014 for the remaining balance payable of $1,852. The Carmichael Note is payable in one interest only payment of $75 due on October 22, 2014 and five semi-annual installments of $185 of principal and accrued interest commencing on April 22, 2015, with the remaining balance of the Carmichael Note of $1,255 due October 22, 2017. Interest is payable in arrears semi-annually on the six and twelve-month anniversary of the issuance of the note. The Carmichael Note is guaranteed by the Company.

***Termination and Repayment of Credit Facility*** On April 23, 2008, SunLink and substantially all of its subsidiaries entered into a $47,000 seven-year senior secured credit facility ( Credit Facility ) initially 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 was subsequently amended by eight modification agreements as a result of which the Revolving Loan commitment was reduced to $9,000 as of September 20, 2012 and the termination date of the Credit Facility was established as January 1, 2013. As of December 31, 2012, the Company paid all outstanding amounts under the Revolving Loan and the Term Loan and the Credit Facility was terminated. Financing costs and expenses related to the Credit Facility of $2,710 were amortized over the modified life of the Credit Facility. Amortization expense related to the Credit Facility was approximately $0, $222 and $201, respectively, for the fiscal years ended June 30, 2014, 2013 and 2012.

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

| | |
|---|---|
| 2015 | $ 5,378 |
| 2016 | 767 |
| 2017 | 808 |
| 2018 | 1,839 |
| 2019 | 620 |
| 2020 and thereafter | 7,939 |
| Total | $ 17,351 |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

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, 2014.

| | |
|---|---|
| 2015 | $ 981 |
| 2016 | 731 |
| 2017 | 678 |
| 2018 | 577 |
| 2019 | 490 |
| 2020 and thereafter | 2,771 |
| Total | $ 6,228 |

**10. SHAREHOLDERS EQUITY**

***Employee and Directors Stock Option Plans*** On November 7, 2011, the 2011 Director Stock Option Plan was approved by SunLink s shareholders at the Annual Meeting of Shareholders. This plan permits the grant of options to non-employee directors of SunLink for the purchase of up to 300,000 common shares through September 2012. Options for 140,000 shares were granted during fiscal 2013. No options have been exercised under this plan. Options outstanding under the plan were 231,000 at June 30, 2014. Options available for future issuance under the plan were 69,000 at June 30, 2014.

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. 120,000 options were granted during fiscal 2013. Options outstanding under this Plan were 317,999, 369,999 and 289,999 at June 30, 2014, 2013 and 2012, respectively. Options available for future issuance under the plan were 412,676 at June 30, 2014.

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 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 0, 37,500 and 37,500 at June 30, 2014, 2013 and 2012 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 591,909 shares under this plan have been exercised. There were no options outstanding under this Plan at June 30, 2014 and 2013. Options outstanding under this Plan were 3,000 at June 30, 2012. No additional awards may be granted under this Plan.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

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, 2011 | 174,249 | $ 5.80 | $ 2.50 $9.63 |
| Granted | 250,000 | 1.97 | 1.67 2.09 |
| Forfeited | (23,750) | 2.67 | 2.50 3.00 |
| Options outstanding June 30, 2012 | 400,499 | $ 2.62 | $ 1.67 $9.63 |
| Granted | 260,000 | 1.22 | 1.22 |
| Forfeited | (43,000) | 2.13 | 2.09 2.65 |
| Options outstanding June 30, 2013 | 617,499 | $ 1.92 | $ 1.22 $9.63 |
| Granted | 21,000 | 0.71 | 0.71 |
| Forfeited | (89,500) | 2.15 | 1.22 2.90 |
| Options outstanding June 30, 2014 | 548,999 | $ 1.92 | $ 0.71 $9.63 |
| Options exercisable June 30, 2012 | 220,498 | $ 4.75 | $ 1.67 $9.63 |
| Options exercisable June 30, 2013 | 404,163 | $ 3.18 | $ 1.22 $9.63 |
| Options exercisable June 30, 2014 | 448,998 | $ 2.97 | $ 0.71 $9.63 |

The weighted-average fair value of each option granted during the years ended June 30, 2014, 2013 and 2012 was $0.71, $1.22 and $2.09, respectively. 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, 2014: estimated volatility of 93%; risk-free interest rate of 0.89%; dividend yield of 0%; and an expected life of 5 years. 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, 2013: estimated volatility of 80%; risk-free interest rate of 0.89%; dividend yield of 0%; and an expected life of 6 years. 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, 2012: estimated volatility of 76%; risk-free interest rate of 1.34%; dividend yield of 0%; and an expected life of 6 years. The historical volatility is used to calculate the estimated volatility. The expected life of each 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, 2014, 2013, and 2012, the Company recognized $48, $86 and $92, respectively, of compensation expense for share options issued. As of June 30, 2014, there was $16 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 years ended June 30, 2015, 2016 and 2017.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

Information with respect to stock options outstanding and exercisable at June 30, 2014 is as follows:

| Exercise Prices | Number Outstanding | Weighted-Average Remaining Contractual Life (in years) | Number Exercisable |
|---|---|---|---|
| $ 0.71 | 21,000 | 9.22 | 21,000 |
| $ 1.22 | 230,000 | 8.19 | 170,000 |
| $ 1.67 | 70,000 | 7.37 | 70,000 |
| $ 2.09 | 120,000 | 7.21 | 79,999 |
| $ 2.51 | 8,000 | 4.23 | 8,000 |
| $ 6.55 | 33,000 | 2.88 | 33,000 |
| $ 8.00 | 33,999 | 3.24 | 33,999 |
| $ 9.63 | 33,000 | 1.36 | 33,000 |
| | 548,999 | 6.81 | 448,998 |

No options were exercised during the years ended June 30, 2014, 2013 and 2012. As of June 30, 2014 and 2013, the aggregate intrinsic value of options outstanding and options exercisable were $0 and $0, respectively, for both years.

***Tender Offer*** On February 5, 2013, the Company announced the commencement of a tender offer to purchase at the price of $1.50 per share in cash all of its common shares held by holders of 99 or fewer shares ( odd lots ) who owned such shares as of the close of business on January 31, 2013 ( Odd Lot Tender Offer ). In addition to the $1.50 per share price, the Company offered each eligible tendering holder a bonus of one hundred dollars ($100) upon completion of the Odd Lot Tender Offer for the tender of all shares beneficially owned by such holder which were received and not withdrawn prior to the date of expiration of the Odd Lot Tender Offer, which was March 26, 2013. In accordance with the terms and conditions of the Offer, SunLink accepted for purchase a total of 2,631 common shares of SunLink tendered by 68 holders pursuant to the Offer. As a result of the completion of the Offer, immediately following payment for the tendered shares, the Company had approximately 9,443,334 common shares issued and outstanding and held by approximately 480 stockholders of record. The shares repurchased were retired immediately. The aggregate cash cost of the Odd Lot Tender Offer was $195 and was recorded in equity. Included in the cash cost are purchase price for the odd lot shares of $4, aggregate bonus payments of $7 and fees and expenses of $184.

The primary purpose of the Odd Lot Tender Offer was to reduce the number of holders of record of the Company s common shares in order to permit the Company to deregister the common shares with the SEC. The Company s Board and management each believes that deregistering the Company s common shares will result in significant cost savings. Since the Offer failed to accomplish the objective of reducing the number of record holders to fewer than 300, SunLink anticipates that it will take further actions to reduce the number of holders of record of the Company s common shares in order to permit the Company to deregister the common shares with the SEC.

***Private Placement of Shares*** In the first quarter of fiscal 2012, 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 shares over the prior ten trading days (on which the Company s shares traded) with a minimum placement of $2,500.

On July 28, 2011, SunLink announced the sale of approximately 1,329,000 common shares at approximately $1.90 per share. Such shares were sold to certain of the Company s officers and directors and/or their affiliates. The net proceeds of the private placement of approximately $2,500 were used, together with the

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

Company s operating funds, to make an $8,000 pre-payment on the then outstanding Credit Facility Term Loan. A special committee of the Company s Board of Directors comprised of non-participating 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. No additional shares were sold pursuant to the private placement.

***Shareholder Rights Plan*** On February 10, 2014, the Board of Directors of the Company adopted a new Shareholder Rights Plan (the Plan ). The Plan is intended to encourage fair treatment of shareholders should a take-over bid be made for the Company and provide the Board of Directors of the Company (the Board ) and the shareholders more time to consider any unsolicited take-over bid. Unless otherwise terminated in accordance with its terms, the Plan will terminate on February 9, 2021.

The Rights issued under the Plan will become exercisable only when a person (including any party related to it) acquires or announces its intention to acquire 20% or more of the outstanding shares of the Company. Should such acquisition occur, each right will, upon exercise, entitle a right holder other than the acquiring person or related persons to purchase shares of SunLink Health Systems at a substantial discount to the market price at that time. The Plan is similar to SunLink s previous Shareholder Rights Plan adopted by the company in 2004 which expired on February 8, 2014.

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 expired on February 8, 2014.

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

| | Minimum Pension Liability Adjustment | Accumluated Other Comprehensive Loss |
|---|---|---|
| June 30, 2011 | $ (278) | $ (278) |
| Current period change | (219) | (219) |
| June 30, 2012 | (497) | (497) |
| Current period change | 91 | 91 |
| June 30, 2013 | (406) | (406) |
| Current period change | 72 | 72 |

| | | |
|---|---|---|
| June 30, 2014 | $ (334) | $ (334) |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

## 11. INCOME TAXES

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

| | Year ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Current | $ 324 | $ (4,220) | $ (768) |
| Deferred | (236) | 2,914 | 203 |
| Total income tax expense (benefit) | $ 88 | $ (1,306) | $ (565) |

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

| | June 30, | |
|---|---|---|
| | 2014 | 2013 |
| Net operating loss carryforward | $ 4,288 | $ 3,279 |
| Depreciation expense | (2,099) | (2,546) |
| Allowances for receivables | 2,341 | 2,571 |
| EHR Deferred gain | 0 | 461 |
| Accrued expenses | 1,549 | 1,868 |
| Intangible assets | 3,223 | 3,762 |
| Pension liabilities | 218 | 313 |
| Other | 467 | 564 |
| | 9,987 | 10,272 |
| Less valuation allowance | (2,577) | (2,151) |
| Net deferred income tax assets | $ 7,410 | $ 8,121 |

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

| | Year ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Income tax at Federal statutory rate | $ (443) | $ (983) | $ (909) |
| Changes in valuation allowance continuing operations | 427 | 106 | (33) |
| U.S. state income taxes, net of federal benefit | 31 | (476) | (9) |

| | | | |
|---|---|---|---|
| Share option expense | 16 | 29 | 31 |
| Amortization | 1 | 0 | 316 |
| Other | 56 | 18 | 39 |
| Total income tax expense (benefit) continuing operations | $ 88 | $ (1,306) | $ (565) |

The Company provided a $2,577 deferred tax valuation allowance as of June 30, 2014 so that the net deferred income tax assets were $7,410 as of June 30, 2014. 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 ended June 30, 2014 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 $2,151 deferred tax valuation allowance as of June 30, 2013 so that the net deferred tax assets were $8,121 as June 30, 2013. The net operating loss carryforwards expire in 2023.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

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. The Company classifies interest and penalties related to unrecognized tax benefits as part of its provision for income taxes. Accordingly, included in the liability for unrecognized tax benefits was a liability of $229 as of June 30, 2013. There was no liability for unrecognized tax benefits as of June 30, 2014.

A reconciliation of the beginning and ending amounts of unrecognized tax benefits, included interest and penalties from July 1, 2010 through June 30, 2014 is presented below:

| | |
|---|---|
| Balance at June 30, 2011 | $ 37 |
| Reductions for tax positions of prior years | (18) |
| Balance at June 30, 2012 | 19 |
| Additions based on tax positions related to current year | 218 |
| Reductions for tax positions related to current year | (1) |
| Reductions for tax positions of prior years | (7) |
| Balance at June 30, 2013 | 229 |
| Reductions for tax positions of prior years | (229) |
| Balance at June 30, 2014 | $ 0 |

**12. 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 1997, SunLink had maintained defined benefit retirement plans covering substantially all of its domestic 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.

Since the sale of SunLink s life sciences and engineering segment businesses in the fiscal year ended March 31, 1999, net pension expense has been classified as an expense of discontinued operations.

At June 30, 2014, the plan s assets were invested 59% in cash and short term investments, 26% in equity investments and 15% 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% is based upon the plan s historical return on

assets. The plan expects to pay $74, $59, $62, $66, and $64 in pension benefits in the years ending June 30, 2015 through 2019, respectively. The plan expects to pay $337 in pension benefits for the years June 30, 2020 through 2023, 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 a contribution of $108 to the plan for the year ended June 30, 2014 and plans to make a contribution of $120 to the plan for the year ended June 30, 2015.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

The components of net pension expense for all plans (comprised solely of one domestic plan) were as follows:

| | Years Ended June 30, | | |
|---|---|---|---|
| | 2014 | 2013 | 2012 |
| Service cost | $ 0 | $ 0 | $ 0 |
| Interest cost | 59 | 68 | 74 |
| Expected return on assets | (30) | (40) | (41) |
| Amortization of prior service cost | 129 | 108 | 55 |
| Settlement cost | 0 | 118 | 0 |
| Net pension expense | $ 158 | $ 254 | $ 88 |
| Weighted -average assumptions: | | | |
| Discount rate | 4.50% | 4.50% | 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 one domestic plan) is as follows:

| | 2014 | 2013 |
|---|---|---|
| **Change in Benefit Obligation:** | | |
| Benefit obligation at beginning of year | $ 1,353 | $ 1,536 |
| Interest cost | 59 | 68 |
| Actuarial loss | 0 | 41 |
| Benefits paid | (46) | (292) |
| Benefit obligation end of year | $ 1,366 | $ 1,353 |
| **Change in Fair Value of Plan Assets:** | | |
| Beginning fair value | $ 737 | $ 985 |
| Actual return on plan assets | 17 | 1 |
| Employer contribution | 108 | 43 |
| Benefits paid | (46) | (292) |
| Plan assets at end of year | $ 816 | $ 737 |
| Funded status of the plans | (549) | (616) |
| Unrecognized actuarial loss | 535 | 652 |
| Prepaid (accrued) benefit cost | $ (14) | $ 36 |

**Amounts Recognized in Consolidated Balance Sheets**

| | | |
|---|---|---|
| Prepaid (accrued) benefit cost | (14) | 36 |
| Accumulated other comprehensive loss* | 535 | 652 |
| Net amount recognized | $ (549) | $ (616) |

* 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. A match of $120 was provided for the fiscal year ended June 30, 2014. No match was provided for the fiscal years ended June 30, 2013 and 2012. Plan expense for the defined contribution plan was $0 for the years ended June 30, 2014, 2013 and 2012.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

## 13. COMMITMENTS AND CONTINGENCIES

***Leases*** The Company leases various land, buildings, and equipment under operating lease obligations having noncancelable terms ranging from one to 13 years. Rent expense was $1,775, $1,918, and $2,191, for the years ended June 30, 2014, 2013 and 2012, respectively. Minimum lease commitments as of June 30, 2014 are as follows:

| | |
|---|---|
| Fiscal year ending June 30: | |
| 2015 | $ 1,549 |
| 2016 | 847 |
| 2017 | 700 |
| 2018 | 281 |
| 2019 | 29 |
| 2020 and thereafter | 11 |
| | $ 3,417 |

***Physician Guarantees*** At June 30, 2014, SunLink had a guarantee agreement with one physician. 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 this one guarantee have been paid as of June 30, 2014. SunLink expensed $110, $137, and $340, for the fiscal years ended June 30, 2014, 2013 and 2012, respectively. There were no remaining non-cancelable commitments under guarantee agreements with physicians as of June 30, 2014.

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

On April 11, 2012, the Court granted SHC-Ellijay s motion for partial summary judgment and denied Defendants motions for summary judgment. In April 2012, Defendants filed a notice of appeal to the Georgia Court of Appeals. In March 2013, the Georgia Court of Appeals issued an opinion affirming in part and reversing in part the summary judgment entered for the Company. The appellate court rejected all of the Sellers various contract-law defenses. The appellate court also held that the Sellers intentionally breached the Option Agreement by failing to close the transaction and satisfy their other obligations. The appellate court reversed, however, on the question of whether Sellers breach was also willful, reasoning that willfulness carries with it an aspect of bad faith. The case has been remanded to the Superior Court for trial on the willfulness/bad faith issue and damages. A settlement has been pursuant to which James Garrett, as sole owner of the real property, would issue

in satisfaction of the Company s claims a five year promissory note in the principal amount of $600 to Castlemark Properties, LLC, one of the Company s subsidiaries, such note to be secured by a mortgage on the real property. Such settlement is conditioned on Mr. Garrett obtaining a corrective deed from the Georgia Department of

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

Transportation for a portion of the property. If the settlement closes, the lawsuit will be discussed and, if not, the litigation may resume. While the ultimate outcome and materiality of the litigation cannot be determined, in management s opinion the litigation should not have a material adverse effect on SunLink s financial condition or results of operations.

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

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

**14. 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. The Company has expensed an aggregate of $689, $1,004, and $1,092 to these law firms in the fiscal years ended June 30, 2014, 2013 and 2012, respectively. Included in the Company s consolidated balance sheets at June 30, 2014 and 2013 is $115 and $216, respectively, of amounts payable to these law firms.

**15. 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.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

We evaluate performance of our operating segments based on revenue and operating profit (loss). Segment information for the fiscal years ended June 30, 2014, 2013 and 2012 is as follows:

| 2014 | Healthcare Facilities | Specialty Pharmacy | Corporate and Other | Total |
|---|---|---|---|---|
| Net Revenues from external customers | $ 71,647 | $ 33,322 | $ 461 | $ 105,430 |
| Operating profit (loss) | 4,231 | 483 | (4,754) | (40) |
| Depreciation and amortization | 2,076 | 730 | 856 | 3,662 |
| Assets | 37,481 | 11,321 | 15,045 | 63,847 |
| Expenditures for property, plant and equipment | 660 | 711 | 352 | 1,723 |
| **2013** | | | | |
| Net Revenues from external customers | $ 74,909 | $ 33,314 | $ 85 | $ 108,308 |
| Operating profit (loss) | 4,235 | 163 | (5,493) | (1,095) |
| Depreciation and amortization | 2,493 | 729 | 826 | 4,048 |
| Assets | 38,904 | 10,948 | 18,151 | 68,003 |
| Expenditures for property, plant and equipment | 2,522 | 551 | 1,902 | 4,975 |
| **2012** | | | | |
| Net Revenues from external customers | $ 74,703 | $ 38,099 | $ 414 | $ 113,216 |
| Operating profit (loss) | 6,312 | 488 | (4,644) | 2,156 |
| Depreciation and amortization | 2,642 | 815 | 908 | 4,365 |
| Assets | 48,895 | 11,652 | 18,625 | 79,172 |
| Expenditures for property, plant and equipment | 976 | 455 | 87 | 1,518 |

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

**16. EARNINGS PER SHARE**
**(Share Amounts in Thousands)**

| | Years Ended June 30, | | | | | |
|---|---|---|---|---|---|---|
| | 2014 | | 2013 | | 2012 | |
| | Amount | Per Share Amount | Amount | Per Share Amount | Amount | Per Share Amount |
| Earnings (loss) from continuing operations | $ (1,391) | | $ (1,585) | | $ (1,676) | |
| Basic: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ (0.15) | 9,445 | $ (0.17) | 9,350 | $ (0.18) |
| Diluted: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ (0.15) | 9,445 | $ (0.17) | 9,350 | $ (0.18) |
| Earnings from discontinued operations | $ 846 | | $ 6,073 | | $ 2,757 | |
| Basic: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ 0.09 | 9,445 | $ 0.64 | 9,350 | $ 0.29 |
| Diluted: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ 0.09 | 9,445 | $ 0.64 | 9,350 | $ 0.29 |
| Net Earnings (loss) | $ (545) | | $ 4,488 | | $ 1,081 | |
| Basic: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ (0.06) | 9,445 | $ 0.48 | 9,350 | $ 0.12 |
| Diluted: | | | | | | |
| Weighted-average shares outstanding | 9,443 | $ (0.06) | 9,445 | $ 0.48 | 9,350 | $ 0.12 |
| Weighted-average number of shares outstanding basic | 9,443 | | 9,445 | | 9,350 | |
| Effect of dilutive director, employee and guarantor options and outstanding common share warrants | 0 | | 0 | | 0 | |
| Weighted-average number of shares outstanding diluted | 9,443 | | 9,445 | | 9,350 | |

Share options of 298, 617 and 411 for the years ended June 30, 2014, 2013 and 2012, respectively, are not included in the computation of diluted earnings per share because their effect would be antidilutive.

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**SUNLINK HEALTH SYSTEMS, INC.**

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)**

**17. SELECTED QUARTERLY FINANCIAL DATA (UNAUDITED)**
**(All amounts in thousands, except per share amount)**

The following selected quarterly data for the years ended June 30, 2014 and 2013, respectively, are unaudited.

| | | Fourth Quarter | Third Quarter | Second Quarter | First Quarter |
|---|---|---|---|---|---|
| NET REVENUE | Year Ended June 30, 2014 | $ 25,070 | $ 27,718 | $ 27,064 | $ 25,578 |
| | Year Ended June 30, 2013 | 25,445 | 29,319 | 27,850 | 25,694 |
| EARNINGS (LOSS) FROM CONTINUING OPERATIONS | Year Ended June 30, 2014 | 707 | (911) | (13) | (1,174) |
| | Year Ended June 30, 2013 | 1,629 | (197) | (1,395) | (1,622) |
| NET EARNINGS (LOSS) | Year Ended June 30, 2014 | 1,350 | (964) | 227 | (1,158) |
| | Year Ended June 30, 2013 | 2,163 | (186) | 3,935 | (1,424) |
| EARNINGS (LOSS) PER SHARE: | | | | | |
| Continuing operations | | | | | |
| Basic | Year Ended June 30, 2014 | 0.07 | (0.10) | (0.00) | (0.12) |
| | Year Ended June 30, 2013 | 0.17 | (0.02) | (0.15) | (0.17) |
| Diluted | Year Ended June 30, 2014 | 0.07 | (0.10) | (0.00) | (0.12) |
| | Year Ended June 30, 2013 | 0.17 | (0.02) | (0.15) | (0.17) |
| NET EARNINGS (LOSS): | | | | | |
| Basic | Year Ended June 30, 2014 | 0.14 | (0.10) | 0.02 | (0.12) |
| | Year Ended June 30, 2013 | 0.23 | (0.02) | 0.42 | (0.15) |
| Diluted | Year Ended June 30, 2014 | $ 0.14 | $ (0.10) | $ 0.02 | $ (0.12) |
| | Year Ended June 30, 2013 | $ 0.23 | $ (0.02) | $ 0.42 | $ (0.15) |
| WEIGHTED-AVERAGE COMMON SHARES OUTSTANDING: | | | | | |
| Basic | Year Ended June 30, 2014 | 9,443 | 9,443 | 9,447 | 9,443 |
| | Year Ended June 30, 2013 | 9,443 | 9,446 | 9,446 | 9,446 |
| Diluted | Year Ended June 30, 2014 | 9,476 | 9,443 | 9,447 | 9,443 |
| | Year Ended June 30, 2013 | 9,443 | 9,446 | 9,446 | 9,446 |