SUNLINK HEALTH SYSTEMS INC
Form 10-K
September 26, 2008
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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, 2008

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	American Stock Exchange

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

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

Large accelerated filer ¨	Accelerated filer ¨
Non-accelerated filer ¨	Smaller reporting company x

(Do not check if a smaller reporting company)

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

At the close of business on September 24, 2008, there were 7,936,800 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, 2007 of the registrant s common shares as reported by the American Stock Exchange amounted to $29,700,000.

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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, 2008, have been incorporated by reference into Part III of this Report. The Proxy Statement will be filed with the Securities and Exchange Commission within 120 days after June 30, 2008.

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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;

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

demographic changes in areas where we operate;

the availability of cash or borrowings to fund working capital, renovations, replacement, expansion and capital improvements at existing hospital facilities and for acquisitions and replacement hospital 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 profitability 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;

restrictions imposed by debt agreements;

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

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

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

changes in medical and other technology;

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

increases in prices of materials and services utilized in our hospital and pharmacy operations;

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

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

the functionality or costs with respect to our management information system for our hospitals, including both software and hardware;

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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

weather-related events such as flooding, and wind damage and population evacuations affecting areas we operate including Louisiana and South Georgia.

Regulation and Governmental Activity

existing and proposed governmental budgetary constraints;

the regulatory environment for our businesses, including state certificate of need 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;

changes in or failure to comply with Federal, state or local laws and regulations affecting the healthcare industry; and,

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

Acquisition Related Matters

the availability and terms of capital to fund additional acquisitions or replacement facilities;

impairment or uncollectibility of certain acquired assets;

Assumed liabilities discovered subsequent to an acquisition;

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

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

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

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

We are SunLink Health Systems, Inc. Unless the context indicates otherwise, all references to SunLink, we, our, ours, us and the Company to SunLink Health Systems, Inc. and our consolidated subsidiaries. We are a provider of healthcare services in certain rural and exurban markets in the United States. References to our specific operations refers to operations conducted through our subsidiaries and references to we, our, ours, and us in such context refers to the operations of our subsidiaries. Our business is composed of two business segments, healthcare facilities and pharmacy operations. Through our subsidiaries, we operate a total of seven community hospitals in four states. Six of the community hospitals are owned and one is leased. Our community hospitals are acute care hospitals and have a total of 402 licensed beds. As part of our community hospital operations, we currently also operate (a) three nursing homes in two states, each of our current nursing homes is located adjacent to, or in close proximity with, certain of our community hospitals, and (b) four home healthcare agencies in three states, each of our current home health agencies is operated from certain of our community hospitals. Our nursing homes have a total of 261 licensed beds. Through a subsidiary acquired in April 2008, we also operate a specialty pharmacy business with four service lines. Our healthcare operations are conducted through our direct and indirect subsidiaries, including SunLink Healthcare LLC (SHL), HealthMont LLC (HealthMont) and SunLink ScriptsRx, LLC (ScriptsRx).

Our executive offices are located at 900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339, and our telephone number is (770) 933-7000. Our website address is www.sunlinkhealth.com. Information contained on our website does not constitute part of this report. Any materials we file with the Securities and Exchange Commission (SEC) may be read at the SEC s Public Reference Room at 100 F Street, NE, Room 1580 Washington, DC 20549. Information on the operation of the Public Reference Room may be obtained by calling the SEC at (202) 551-8090. Certain materials we file with the SEC may also be read and copied at or through our website.

History

We are an Ohio corporation and were incorporated in June 1959. In fiscal 2001 we redirected our business strategy toward healthcare services in the United States. On February 1, 2001, we purchased five community hospitals, leasehold rights for a sixth hospital and the related businesses of all six hospitals for approximately $26,500. On October 3, 2003, we acquired two additional hospitals through our acquisition of HealthMont, Inc. In June 2004, we sold our Mountainside Medical Center (Mountainside) facility, a 35-bed hospital located in Jasper, GA for approximately $40,000. On April 23, 2008, we acquired Carmichael for approximately $24,000.

Business Strategy: Operations, Acquisitions and Strategic Alternatives

SunLink s business strategy is to focus its efforts on internal growth of its existing healthcare facilities and its pharmacy business, supplemented by growth from selected rural and exurban healthcare acquisitions, including but not limited to hospitals, nursing homes, home care businesses, and pharmacy businesses. However, as was the case in 2004 with our Mountainside Medical Center hospital, we do consider disposition of one or more of our facilities based on a variety of factors including asset values, return on investments, competition from existing and potential facilities and capital improvement needs. We likewise evaluate our strategic alternatives on an on-going basis.

Operations

Our operational strategy is focused on efforts to increase internal growth. Our primary operational strategy for our community hospitals is to improve the profitability of such hospitals by reducing out-migration of patients, recruiting physicians, expanding services and implementing and maintaining effective cost controls. Our

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operational strategy for our nursing homes and home health agencies is similar to that for our community hospitals and is focused on expanding services and implementing and maintaining effective cost controls.

Finally, our operation strategy for our pharmacy operations is focused on integrating the recently acquired operations, increasing market share, increasing collection efforts, expanding services and implementing and maintaining effective cost controls.

Acquisitions

During the last fiscal year, we evaluated certain rural and exurban hospitals and healthcare businesses, which were for sale and monitored other selected rural and exurban healthcare acquisition targets which we believed might become available for sale.

On April 22, 2008, SunLink ScriptsRx, LLC acquired Carmichael s Cashway Pharmacy, Inc. (Carmichael). The Carmichael acquisition purchase price was $24,000, consisting of $19,000 cash, seller subordinated debt of $3,000 and $2,000 in SunLink shares (334,448 shares). Carmichael had annual revenues of approximately $42,200 for its year ended December 31, 2007 and has been in business for over 35 years. Carmichael provides services to patients in rural communities in southwest Louisiana and eastern Texas. Carmichael is included in our Specialty Pharmacy Segment.

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

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

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

Our primary market criteria for healthcare facility acquisitions continues to be community hospitals with net revenues of approximately $10,000 or more which are (1) the sole or primary hospital in market areas with a population of greater than 15,000 or (2) a principal healthcare provider with substantial market share in communities with a population of 50,000 to 150,000. We believe all of our seven existing hospitals meet at least one of the two market area criteria.

We face competition 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. Increased competition for the acquisition of non-urban acute-care hospitals and other healthcare facilities could have an adverse impact on our ability to acquire such hospitals and other healthcare facilities on favorable terms or at all,

We consider prices paid by others in recent years for certain hospital acquisitions to be higher than we would be willing to pay but we believe there may be opportunities for acquisitions of individual hospitals in the

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

Opportunities to acquire not-for-profit hospitals may improve. However, in recent years, the legislatures and attorneys general of several states (including Georgia and other states which we believe may have suitable acquisition targets) have shown a heightened level of interest in reviewing transactions involving the sale of not-for-profit hospitals. The legal authority for such review is generally known as Conversion Legislation. Although the level of authority for, and interest in, such reviews varies from state to state, the trend is toward increased governmental review authority for, and, in some cases, imposing conditions prior to, the approval of transactions involving a not-for-profit corporation selling a healthcare facility. Accordingly, even where the costs of acquiring not-for-profit hospitals improve, governmental review may make it more difficult to complete any such acquisitions.

Our acquisition strategy for nursing homes and home health operations is to acquire businesses in areas which are complementary to either our existing hospitals or our new pharmacy business or which are located in rural or exurban markets. Although we are focused on the internal growth and integration of our recently acquired pharmacy operations into our existing operations, our acquisition strategy for pharmacy operations similarly would be to acquire pharmacy operations in areas which are complementary to either our existing healthcare facility operations or our new pharmacy operations or which are located in rural or exurban markets.

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

We also may, from time to time, consider the acquisition of other rural and exurban healthcare businesses which are not current part of our service lines or business segments.

Strategic Alternatives

On November 8, 2007, we announced that we had received an unsolicited conditional acquisition proposal from Resurgence Health Group, LLC which purported to offer a cash price of $7.50 per share for substantially all the outstanding shares of SunLink, subject to a number of conditions. On January 16, 2008, we announced that we had retained Stephens Inc. for the purpose of advising our Board of Directors in connection with an evaluation of the Company s strategic alternatives, including, among others, the proposal by Resurgence Health Group, LLC. Since retaining Stephens, SunLink has explored a number of strategic alternatives, none of which to date has been judged by our Board to be superior in terms of price and execution risk to continuing as an independent company and pursuing SunLink s existing business plans. To continue the evaluation on an on-going basis, the Board has formed a standing Strategic Alternatives Committee of the Board of Directors to, among other things, conduct periodic evaluations of the Company s strategic alternatives. Investors are cautioned that no inference should be drawn from the existence of such committee and its charter with respect to the probability that the Company will engage in any transaction as a result of the periodic evaluation of strategic alternatives, including with respect to any proposal previously submitted or which in the future may be re-submitted or newly presented to the Company.

Healthcare Facilities Operations

SunLink s healthcare facilities segment is composed of three operational areas:

Our seven community hospitals;

Our three nursing homes, each of which is located in adjacent to, or in close proximity with a corresponding SunLink community hospital; and

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Our four hospital related home health agencies, each of which operates for a corresponding SunLink community hospital.

Through our subsidiaries, we operate a total of seven community hospitals in four states. Six of the community hospitals are owned and one is leased. SunLink s community hospitals are acute care hospitals and have a total of 402 licensed beds. In connection with our community hospital operations in certain communities, we also operate (a) three nursing homes located in two states: each of our current nursing homes is located adjacent to our community hospitals, and (b) four home healthcare agencies in three states, each of these home health agencies is operated from one of our community hospitals. Our nursing homes have a total of 261 licensed beds.

Owned and Leased Hospitals

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

Chestatee Regional Hospital (Chestatee), located in Dahlonega, Lumpkin County, Georgia, is a 49-licensed-bed, acute-care hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It includes a 12-bed obstetric department, a four-bed intensive care unit (ICU) and a 33-bed medical/surgical/pediatrics unit. Chestatee is the only hospital in its primary service area of Lumpkin and Dawson Counties.

North Georgia Medical Center (North Georgia), located in Ellijay, Gilmer County, Georgia, consists of a JCAHO accredited 50-licensed-bed, acute-care hospital and Gilmer Nursing Home, a 100-bed skilled nursing facility. North Georgia completed construction of a 6,755-square-foot emergency room addition in January 2003 for approximately $1,700. North Georgia is the only hospital in Gilmer County. The Company has a 28-bed CON to replace the existing hospital.

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

Chilton Medical Center (Chilton), located in Clanton, Chilton County, Alabama, is a 60-licensed-bed, JCAHO accredited, acute-care hospital. It operates a home-health agency. Chilton is the only hospital in Chilton County.

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

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

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

Hospital Operations

Utilization of Local Hospital Management Teams

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

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

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

Expansion of Services and Facilities; Maintenance of Emergency Room Operations

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

Medical Staff

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

Physician Recruiting

Each SunLink hospital management team is responsible for assessing the need for additional physicians, including the number and specialty of additional physicians needed by its community. Each of our local hospital management teams, with the assistance of outside recruiting firms, identifies and seeks to attract specific physicians to its hospital s medical staff. The hospital generally guarantees a newly recruited physician a minimum level of gross receipts during an initial period, generally one year, and assists the physician s transition into the community. The physician is required to repay some or all of the amounts paid under such guarantee if the physician leaves the community within a specified period. SunLink hospitals generally have not employed physicians but are currently considering the employment of certain physicians in markets where it believes it would enhance the hospital s service offerings.

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Operating Statistics

The following table sets forth certain operating statistics for SunLink s healthcare facilities as of June 30, 2008 for the periods indicated.

	Fiscal Years Ended June 30,		
	2006	2007	2008
Hospitals owned or leased at end of period	7	7	7
Licensed hospital beds (at end of period)	402	402	402
Hospital beds in service (at end of period)	295	327	327
Nursing home beds in service (at end of period)	261	261	261
Admissions	9,970	9,908	8,865
Equivalent Admissions(1)	25,163	26,903	25,390
Average length of stay (days)(2)	3.63	3.59	3.54
Patient days	36,176	35,562	31,388
Adjusted patient days(3)	89,305	93,822	88,929
Occupancy rate (% of licensed beds)(4)	24.65%	24.24%	21.39%
Occupancy rate (% of beds in service)(5)	33.51%	29.71%	26.23%
Net patient service revenues (in thousands)	$ 135,576	$ 143,645	$ 151,372
Net outpatient service revenues (in thousands)	$ 59,760	$ 68,234	$ 81,059
Net revenue per equivalent admissions	$ 5,388	$ 5,339	$ 5,962
Net outpatient service revenues (as a % of net patient service revenues)	44.08%	47.50%	53.55%

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

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

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

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

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

Sources of Revenue

Each SunLink hospital receives payments for patient care from Federal Medicare programs for older and disabled patients, state Medicaid programs, private insurance carriers, health maintenance organizations, preferred provider organizations, TriCare (formerly known as the Civilian Health and Medical Program of the Uniformed Services, or CHAMPUS), and from employers and patients directly. See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations .

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

	Fiscal Years Ended June 30,		
	2006	2007	2008
Source			
Medicare	69.2%	70.5%	70.1%
Medicaid	10.7%	10.1%	9.6%
Private and Other Sources	20.1%	19.4%	20.3%
Total	100.0%	100.0%	100.0%

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

	Fiscal Years Ended June 30,		
	2006	2007	2008
Source			
Medicare	38.8%	39.8%	41.6%
Medicaid	16.4%	13.9%	14.1%
Private and Other Sources	44.8%	46.3%	44.3%
Total	100.0%	100.0%	100.0%

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

Patients generally are not responsible for any difference between established hospital charges and amounts reimbursed for such services under Medicare, Medicaid, some private insurer plans, health maintenance organizations (HMO*s*) or preferred provider organizations (PPO*s*), 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.

Medicare is a Federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a Federal-state program, administered by the states, that provides hospital and nursing home benefits to qualifying individuals who are unable to afford care. All of SunLink s hospitals are certified as healthcare services providers for persons covered by Medicare and Medicaid programs. 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. See Item 1. Business Government Reimbursement Programs Medicare/Medicaid Reimbursement .

Quality Assurance

Each SunLink hospital implements quality assurance procedures to monitor the level and quality of care provided to its patients. Each hospital has a medical director who supervises and is responsible for the quality of

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

Competition

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

The appearance and functionality of the healthcare facilities;

The quality and demeanor of professional staff and physicians; and

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

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. Although our hospitals may face less competition in their immediate patient service areas than would be expected in larger communities, since they are the primary provider of healthcare services in their respective communities, our hospitals nevertheless face competition from larger tertiary care centers and, in some cases, other rural, exurban, suburban or, in limited circumstances, urban hospitals, some of which (particularly large urban hospitals) 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, likely have greater access to financial resources than do SunLink hospitals.

Managed Care and Efforts to Control Healthcare Costs

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

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

The healthcare industry as a whole faces the challenge of continuing to provide quality patient care while managing rising costs, facing strong competition for patients, and adjusting to a 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 is designed 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.

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

Government Reimbursement Programs

A significant portion of SunLink s healthcare facilities net revenues is dependent upon reimbursement from Medicare and Medicaid. Although the Federal government generally reviews payment rates under its various programs annually, changes in reimbursement rates under such programs, including Medicare and Medicaid, generally occur based on the fiscal year of the Federal government which currently begins on October 1 and ends on September 30 of each year.

Medicare Inpatient Reimbursement

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

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

DRG rate increases were 3.4%, 3.3%, 3.7%, 3.4%, and 3.5% for Federal fiscal years 2004, 2005, 2006, 2007, and 2008 respectively. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future Federal fiscal years at rates that are based on the market basket index, which in certain years have been, and in the future may be, subject to reduction factors. The Medicare, Medicaid and Health Benefits Improvement and Protection Act of 2000 (BIPA) amended the Balanced Budget Act of 1997 by giving hospitals a market basket increases minus 0.55% in fiscal year 2003. For Federal fiscal year 2004 and thereafter, hospitals received the full market basket rate increase. BIPA also made a number of changes to Medicare and Medicaid affecting payments to hospitals. All of our acute care hospitals qualify for some relief under BIPA. Some of the changes made by BIPA that affect our hospitals include:

- the lowering of the threshold by which hospitals qualify as rural disproportionate share hospitals;
- a decrease in reductions in payments to disproportionate share hospitals that had been mandated by the Balanced Budget Act of 1997 and other Congressional enactments;

an increase in inpatient payments to hospitals;

an increase in certain Medicare payments to certain psychiatric hospitals and units;

an increase in Medicare reimbursement for bad debts;

capping Medicare beneficiary ambulatory service co-payment amounts; and

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an increase in the categories and items eligible for increased reimbursement to hospitals for certain outpatient services rendered on and after April 1, 2001 (which increase includes items such as current cancer therapy drugs, biologicals, and certain medical devices).

If the update factor does not adequately reflect increases in SunLink s cost of providing inpatient services, our financial condition or results of operations could be negatively affected.

In November 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA requires hospitals to report specified quality data in order to receive full market basket rate increase on DRGs. Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points. On February 8, 2006 the President signed into law the Deficit Reduction Act of 2005 (DRA). The DRA provides that, beginning with the payment update for the federal fiscal year beginning October 1, 2006 and each subsequent federal fiscal year, the annual percentage increase amount will be reduced by 2.0 percentage points for specified hospitals that do not submit certain quality data. In addition, the DRA required that CMS begin to expand the starter set of 10 quality measures that have been used since 2003. For the hospital inpatient prospective payment system (IPPS) for the federal fiscal year beginning and after October 1, 2006, CMS added new measures to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program to bring the total to 21 measures for such federal fiscal year and 27 for the federal fiscal years beginning October 1, 2007. All of SunLink s hospitals are currently reporting the quality data and therefore receiving the full market basket rate increase.

Section 5001(c) of the DRA required HHS to implement rules pursuant to which hospitals must report the secondary diagnoses that are present on the admission (POA) of patients. By October 1, 2007, HHS was required to select at least two conditions that are: (1) high cost or high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) reasonably preventable through application of evidence-based guidelines. Beginning October 1, 2008, cases with the selected conditions would not be assigned to a higher paying DRG unless they were present on admission. Currently CMS has selected nine conditions which are subject to such provisions.

MMA made a number of significant changes to the Medicare program, including a number of provisions designed to help strengthen and preserve access to medical care in rural areas by providing higher Medicare payments to small rural hospitals. In addition to a highly publicized prescription drug benefit that is intended to provide direct relief to Medicare beneficiaries, MMA provides a number of direct benefits to hospitals, including, but not limited to:

incorporation of the permanent single base payment or standardized amount for hospitals, resulting in increased payments for hospitals located in rural and small urban areas.

a permanent increase in the base payment rate for rural and small urban hospitals of 1.6% up to the large urban payment rate;

an increase in the cap on disproportionate share payments for rural and small urban hospitals, which, as of April 1, 2004, was increased to 12.0% of total inpatient payments;

extended indefinitely the hold harmless provisions for small rural hospitals and sole community hospitals under the Outpatient Department reform provisions of the MMA (these payment provisions are intended to ensure that small rural hospitals are paid at least as much under the outpatient prospective payment system as they would have received under the cost-based payment methodology in effect before August 2000); and

establishment of a physician incentive program for primary care and certain specialty physicians who provide services to individuals in areas having the fewest physicians available to serve Medicare beneficiaries, among others.

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

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Each year, on or about August 1, the Centers for Medicare & Medicaid Services (CMS) issue a final rule that implements changes to the hospital inpatient prospective payment system (IPPS) for subsequent federal fiscal years. The August 1, 2006 final rule expanded previously implemented changes that according to CMS take significant steps to improve the accuracy of Medicare s payment for inpatient stays. The payment reforms, which are being phased in over time, align hospital payments more closely with the costs of a patient s care by using hospital costs rather than charges, and by accounting more fully for the severity of the patient s condition. The revised payments became effective for discharges on or after October 1, 2006.

The August 1, 2007 final rule adopted pursuant to MMA made further changes designed to continue to improve the accuracy of Medicare s payment under the acute care IPPS. The IPPS payment reforms are designed to restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient s condition. In addition, the rule includes important provisions intended to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. The rule also reduces Medicare payments when a hospital replaces a device that is supplied to the hospital at no or reduced cost.

It is estimated that payments to all hospitals increased by an average of 3.5 percent for the federal fiscal year beginning October 1, 2007 when all provisions of the rule took effect, primarily as a result of a 3.3 percent market basket increase.

Payments to specific hospitals may increase more or less than the average depending on the patient mix of the specific hospital. For instance, urban hospitals generally treat more severely ill patients and are estimated to receive a 3.8 percent increase in payments. The rule created 745 new severity-adjusted DRGs to replace the previous 538 DRGs. Projected aggregate spending will not change as a result of the reforms. However, payments will increase for hospitals serving more severely ill patients and decrease for those serving patients who are less severely ill. The effect of the change in DRGs to our hospitals is unknown and depends on the acuity of services provided to future patients.

The rule also implemented a provision of the DRA that takes the first steps toward preventing Medicare from giving hospitals higher payment for the additional costs of treating a patient who acquires a condition (including an infection) during a hospital stay. Already the feature of many state health care programs, the DRA requires hospitals, effective as of October 1, 2007, to begin reporting secondary diagnoses that are present on the admission of patients, beginning with discharges on or after such date. Beginning on October 1, 2008, cases with these conditions are no longer paid at a higher rate unless these symptoms were present on admission. In order to improve the reliability of care in the nation s hospitals, the rule identifies eight conditions, including three serious preventable events (sometimes called never events) that meet the statutory criteria. The effect of the future implementation of this DRA provision to our hospitals is not known.

Prior to July 1, 2005, long-term care psychiatric units within hospitals were exempt from the prospective payment system, and were reimbursed under the provisions of a cost-based system, subject to specific reimbursement caps. During a three year transition period beginning on July 1, 2005 such units were partially reimbursed based on a prospective payment system based on patient acuity with the remaining portion of the payment continuing to be reimbursed based on a cost based system. Under the transition period for the implementation of this new prospective system was 25% was reimbursed under the PPS system for the year ending June 30, 2006, and 50% was reimbursed under the PPS system for the year ending June 30, 2007 and 75% was reimbursed under the PPS system for the year ending June 30, 2008. Since July 1, 2008, long-term care psychiatric units are being reimbursed solely based on the federal inpatient psychiatric prospective payment rate. SunLink operates one psychiatric unit in one of its hospitals and believes this change will have a minimal effect on SunLink s consolidated revenues.

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Medicare Outpatient Reimbursement

Most outpatient services provided by general hospitals are reimbursed by Medicare under the outpatient prospective payment system. This outpatient prospective payment system is based on a system of Ambulatory Payment Classifications (APC). Each APC is designed to represent a bundle of outpatient services, and each APC is assigned a fully prospective reimbursement rate. Medicare pays a set price or rate for each APC group, regardless of the actual cost incurred in providing care. Each APC rate generally is subject to adjustment each year by an update factor based on a market basket of services index. For calendar years 2004, 2005, 2006, 2007, and 2008 the update factor were 4.5%, 3.3%, 3.7%, 3.4%, and 3.8% respectively. If the update factor does not adequately reflect increases in SunLink s cost of providing outpatient services, our financial condition or results of operations could be negatively affected.

On November 1, 2007 the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating the hospital Outpatient Prospective Payment System (OPPS), effective for services furnished during calendar year (CY) 2008, which encourages higher quality and accessible health care through new payment policies and the reporting of quality measures. The final rule with comment period also updated the payment rates for the revised ambulatory surgical center (ASC) payment system, beginning in CY 2008.

According to CMS The policies of the revised ASC payment system that are reflected in the 2008 payment rates further expand beneficiary choices by providing patients the flexibility to select, in consultation with their physicians, the most appropriate care setting for their particular surgical needs, the revised system takes a major step toward eliminating financial incentives for choosing one care setting over another, thereby placing patients needs first, increasing efficiencies, and leading to savings for both beneficiaries and the Medicare program.

In this final rule, CMS also adopted the use of composite APCs to encourage efficiencies by providing one bundled payment for several major services. According to CMS Composite APCs encourage even greater hospital efficiencies than expanding packaging by making a single payment for the totality of hospital outpatient care provided during an encounter.

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. BIPA provisions, effective for services provided on and after April 1, 2001, stipulate that rural facilities with fewer than 100 beds with a disproportionate share percentage greater than 15% will be classified as a disproportionate share hospital entitled to receive a supplemental disproportionate share payment based on gross DRG payments. Since April 1, 2004, the effective rate has been 12.0% of DRG payments. All of our hospitals were classified as disproportionate share hospitals at June 30, 2008. We estimate that Medicare disproportionate share payments represented approximately 1% of our net patient service revenues for the years ended June 30, 2006, 2007 and 2008.

Recovery Audit Contractors

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 auditing firms to examine Medicare claims filed by healthcare providers. Fees to the RACs are paid on a contingency basis. The RAC program began as a demonstration project in three states (New York, California and Florida), but was made permanent by the Tax Relief and Health Care Act of 2006. CMS plans to expand the RAC program to additional states beginning in 2008

and to have RACs in place in all 50 states by 2010.

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 identified as overpayments will be subject to the Medicare appeals process.

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RACs are paid a contingency fee based on the overpayments they identify and collect. We expect that the RACs will look closely at claims submitted by our facilities in an attempt to identify possible overpayments. Although we believe the claims for reimbursement submitted to the Medicare program are accurate, we cannot predict whether we will be subject to RAC audits in the future, or if audited, what the result of such audits might be.

Medicaid In-Patient and Out Patient Reimbursement

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

In the recent past the various states in which SunLink operates hospitals initiated increased efforts to reduce Medicaid assistance payments. These efforts and reductions have been triggered by an increased effort by CMS to decrease the federal share of payments for Medicaid beneficiaries as well as by the significant increases in program utilization resulting from increased enrollment and from budgetary cuts facing states where SunLink operates. In particular, Georgia, where SunLink operates three hospitals, has begun initiatives to decrease the Medicaid funds paid to providers.

Georgia Historically, the state of Georgia has reimbursed Medicaid providers for inpatient services in a manner similar to the Medicare prospective payment system in that hospitals received a fixed fee for inpatient hospital services based on the established fixed payment amount per discharge for categories of hospital treatment, known as DRGs. These Medicaid DRG payments do not consider a specific hospital s costs, but are statewide rates adjusted for each hospital s capital cost allotment.

Medicaid outpatient services are reimbursed with interim rates based on a facility specific cost to charge ratio. These interim payments are then adjusted subsequent to the end of the cost reporting period to an amount equal to 85.6% of the costs associated with providing care to the Medicaid outpatient population. Beginning in Georgia s fiscal year ended June 30, 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. Since the implementation of the Medicaid HMO program, all SunLink hospitals receive reimbursement from three different contractors instead of a single source prior to the implementation. 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, the SunLink hospitals have contracts the three HMO vendors and services are reimbursed 102% of the current interim rate determined by the Georgia Department of Community Health

Government Reimbursement Program Administration and Adjustments

The Medicare, Medicaid and CHAMPUS TriCare programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review and new 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 to facilities.

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

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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 to SunLink under these reimbursement programs. These audits often require several years to reach the final determination of amounts due. Providers also 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 consolidated results of operations or financial position. Until final adjustment, however, significant issues may remain unresolved and previously determined allowances could become either inadequate or greater than ultimately required.

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

SPECIALITY PHARMACY OPERATIONS

Our Specialty Pharmacy segment is operated through SunLink ScriptsRx, LLC (of which Carmichael s Cashway Pharmacy, Inc. is currently the sole operating subsidiary) and is a pharmacy operations segment is composed of four material service lines:

1. Specialty Pharmacy Services, which services may overlap somewhat with our home health care services by virtue of common methods of delivery, generally in a non-hospital setting but which are not presently conducted in any of our healthcare facilities markets and ordinarily include one or more of the following elements:

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

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

   Products delivered to the 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 the physician office, specialty clinic or patients home.

   The provision of pharmaceuticals or biological not managed under the traditional outpatient prescription drug benefit; and

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

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

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

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

4. Retail Pharmacy Products and Services, consisting primarily of walk-in sales at our three distribution facilities in Louisiana of complementary products including non-specialty pharmaceuticals, vitamins,

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supplements and nutritionals. We view our retail sales operations as a source of incremental revenue to us while providing value added service to our patients in the form of full service pharmacy offerings.

Government Reimbursement Programs

As previously noted, in 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, also known as the Medicare Modernization Act (MMA). Regulations implementing the mandates under the MMA reduced the reimbursement for healthcare providers in urban areas for a number of products and services 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). The Centers for Medicare & Medicaid Services (CMS) had planned to implement the competitive biding 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. The program has, however, been deferred indefinitely, and whether or not the program is implemented in the future is unknown.

We were exempted under the Deficit Reduction Act of 2005 from the proposed competitive acquisition program for DMEPOS, but we cannot be sure such exemption would continue to be available in the future or that the program will be implemented in the future as it was originally designed . Loss of the exemption could have an adverse effect on our results of operation.

The MMA also created a new Medicare prescription drug benefit (beginning in 2006) and, more immediately, a prescription drug card program. On January 21, 2005, the CMS issued final rules implementing the portions of the MMA relating to the new prescription drug benefit.

In addition to these new programs, the MMA also made changes affecting payments for drugs under Medicare s existing benefits. Section 303(c) of the MMA revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. In particular, section 303(c) of the MMA amended Title XVIII of the Act by adding section 1847A, which moved from a system based on average wholesale price or (AWP) to one based on a new average sales price (ASP) drug payment system. Since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology. Principal among these latter changes was a modification in the method of calculating reimbursements for certain oncology, renal dialysis, and other drugs. There are exceptions to this general rule which are listed in the latest ASP quarterly change request (CR) document. The ASP methodology uses quarterly drug pricing data submitted to the CMS by drug manufacturers. CMS will supply contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Beginning in January 2008, CMS s outpatient prospective payment system began paying for most separately payable Medicare Part B drugs administered in a hospital outpatient setting at a reimbursement level of ASP plus 5% and ASP plus 6% in other settings. Such outpatient price represented a decrease from ASP + 6% and is part of a CMS plan to transition to even lower reimbursement rates of ASP +3% in calendar year 2009.

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.

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Submitted applications are now being evaluated by CMS. A three year contract for 2009-2011 will be awarded to vendors for each program geographic area who have and maintain: 1) sufficient means to acquire and deliver competitively biddable drugs within the specified contract area; 2) arrangements in effect for shipping at least 5 days each week for the competitively biddable drugs under the contract and means to ship drugs in emergency situations; 3) quality, service, financial performance and solvency standards; and 4) a grievance and appeals process for dispute resolution. Up to five vendors may be selected, although only one vendor is currently approved. Approved Part B CAP vendors must also qualify for enrollment in Medicare. For 2009-2011, the Part B CAP will continue to have one geographic area which includes all 50 States, the District of Columbia, Puerto Rico, the United States Virgin Islands, American Samoa, Guam and the Northern Mariana Islands. Any Part B CAP Vendor must also be licensed in accordance with state and Federal requirements and in a manner that will allow the applicant to supply CAP drugs in the geographic area.

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 the drugs sold by our specialty pharmacy operations could reduce revenue and gross margins and could materially affect our current AWP based reimbursement structure with private payors.

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

Competition

There are many companies which provide one or more of the healthcare operations which comprise our pharmacy operations. Home healthcare business competitors range in size from small entrepreneurial operations to rapidly expanding businesses with strategies for national operations such as Amedisys, Inc., Apria Healthcare Group, Inc., Gentiva Health Services, Inc., and Walgreen Co. Specialty pharmacy operators 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 MIM Corporation.

Healthcare Regulation

Overview

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

There continue to be Federal and state proposals that would, and actions that do, impose limitations on government and private payments to providers, including community hospitals. In addition, there regularly are proposals to increase co-payments and deductibles from program and

private patients. Hospital facilities also are affected by controls imposed by government and private payors designed to reduce admissions and lengths of stay. Such controls include what is commonly referred to as utilization review . Utilization review entails the review of a patient s admission and course of treatment by a third party. Historically, utilization review has resulted in a decrease in certain treatments and procedures being performed. Utilization review is required in

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connection with the provision of care which is to be funded by Medicare and Medicaid and is also required under many managed care arrangements.

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

Healthcare Facility Regulation

Certificate of Need Requirements

A number of states require approval for the purchase, construction and expansion of various healthcare facilities, including findings of need for additional or expanded healthcare facilities or services. Certificates of need (CON), 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 four states in which SunLink currently operates hospitals (Alabama, Georgia, Mississippi and Missouri) have CON laws that apply to such facilities. The two states (Georgia and Mississippi) in which SunLink currently operates nursing homes/skilled nursing facilities also have CON laws that apply to nursing homes and other skilled nursing facilities. States periodically review, modify and revise their CON laws and related regulations.

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

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

Utilization Review Compliance and Hospital Governance

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

Emergency Medical Treatment and Active Labor Act

All of our facilities are subject to the Emergency Medical Treatment and Active Labor Act (EMTALA) This federal law requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents himself to the hospital s emergency department for treatment and, if the patient is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of a patient s ability to pay for treatment. There are

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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. 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 the hospital.

In a final rule, effective November 10, 2003, CMS clarified when a patient is considered to be on a hospital s property for purposes of treating the person pursuant to EMTALA. CMS stated that off-campus facilities such as specialty clinics, surgery centers and other facilities that lack emergency departments should not be subject to EMTALA, but that these locations must have a plan explaining how the location should proceed in an emergency situation such as transferring the patient to the closest hospital with an emergency department. CMS further clarified that hospital-owned ambulances could transport a patient to the closest emergency department instead of to the hospital that owns the ambulance.

CMS rules did not specify on-call physician requirements for an emergency department, but provided a subjective standard stating that on-call hospital schedules should meet the hospital s and community s needs. CMS also did not directly address a number of issues, including whether EMTALA applies to direct admissions, individuals who come to a hospital pursuant to a physician s orders for a routine procedure, individuals who present themselves at a hospital s psychiatric department or delivery/labor department, and whether screening requirements apply to patients transferred from other facilities. Although we believe that our hospitals comply with EMTALA, we cannot predict whether CMS will implement new requirements in the future and whether we will be able to comply with any new requirements.

Conversion Legislation

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

Pharmacy Operations Regulation

Overview

Much like our healthcare facility operations, our pharmacy operations 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-discriminary access. Federal statutes and regulations govern the labeling, packaging, advertising and adulteration of prescription drugs and 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 and to comply with security, recordkeeping, inventory control and labeling standards in order to dispense controlled substances. Although we believe that our pharmacy operations have obtained or are obtaining the permits and/or licenses required to conduct our pharmacy operations, failure to have the necessary permits and licenses could have a material adverse effect on our pharmacy business, and our financial condition or results of operations.

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Mail Order Activities

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

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

Advertising and Marketing Regulations

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

Healthcare Regulations of General Application

Licensing Requirements

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

Drugs and Controlled Substances

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

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

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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 performs any of the following acts:

making claims to Medicare and/or Medicaid for services not provided or misrepresenting actual services provided in order to obtain higher payments;

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

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

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 Medicaid, Medicare or other Federal 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, the U.S. Department of Health and Human Services (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 new 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 new enforcement mechanisms to combat fraud and abuse. These new 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 expands the categories of persons that may be excluded from participation in federal and state healthcare programs.

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

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

healthcare programs.

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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. 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

A significant factor affecting the healthcare industry today is the use of the Federal False Claims Act, 31 U.S.C. § § 3729 *et. seq*., and, in particular, actions brought by individuals on behalf of the United States under the qui tam or whistleblower provisions of the False Claims Act. Whistleblower provisions allow private individuals to bring actions on behalf of the United States alleging that the defendant has defrauded the Federal Government.

Violations of the False Claims Act are punishable by damages equal to three times the actual damages sustained by the government, plus mandatory civil penalties of between $6 and $11 for each separate false claim. Settlements entered prior to litigation usually involve a less severe damages methodology. There are many potential bases for liability under the False Claims Act. Liability often arises when an entity knowingly submits a false claim for reimbursement to the Federal Government. The False Claims Act defines the term knowingly broadly. Thus, although simple negligence will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard for its truth or falsity constitutes a knowing submission under the False Claims Act and, therefore, will provide grounds for liability. In some cases whistleblowers or the Federal government have taken the position that providers who allegedly have violated other statutes, such as the anti-kickback statute and the Stark Act, likewise thereby have submitted false claims under the False Claims Act. A number of states have adopted their own false claims provisions as well as their own whistleblower provisions whereby a private party may file a civil lawsuit in state court on behalf of such state governments.

HIPAA Transaction, Privacy and Security Requirements

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

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

HIPAA Privacy Regulations

HIPAA provided that if Congress did not pass comprehensive health privacy legislation, the Secretary of HHS was required to issue regulations designed to protect the privacy of individually identifiable health information. Congress did not pass such legislation and HHS ultimately published final privacy regulations in 2000. The final privacy rule regulations contained technical corrections and additional clarifications designed to ensure that protections for patient privacy were implemented in a manner that maximizes privacy while not

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compromising either the availability or the quality of medical care. The regulations became effective in April 2001 and compliance was required by April 2003. In 2002, HHS published modifications to the privacy rule regulation. The regulations increased consumers control over their 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 health information only be used for healthcare-related purposes. These privacy standards apply to all health plans, all healthcare clearinghouses and healthcare providers, such as our facilities, that transmit health information in an electronic form in connection with standard transactions, and apply to individually identifiable information held or disclosed by a covered entity in any form. These standards impose extensive administrative requirements on our facilities and require compliance with rules governing the use and disclosure of this health information, and they require our facilities to impose these rules, by contract, on any business associate to whom we disclose such information in order to perform functions on behalf of our facilities. In addition, our facilities will continue to remain subject to any state laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary by state and could impose stricter standards and additional penalties.

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

HIPAA Electronic Data Standards

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

In 2000, HHS published final regulations establishing electronic data transmission standards that all healthcare providers and payors must use when submitting and receiving certain electronic healthcare transactions. When fully implemented, 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. Compliance with these standards was required by October 2003. We believe that SunLink was fully compliant with the regulations and standards by the compliance date. We have implemented a new management information system at our facilities and at our corporate headquarters over the last several years and we believe that such system complies with HIPAA electronic data regulations and standards.

HIPAA Security Standards

The Administrative Simplification Provisions of HIPAA also required the implementation of a series of security standards for the protection of electronic health information. The final rule adopting HIPAA standards for the security of electronic health information required compliance by April 20, 2005. This final rule specifies a series of administrative, technical and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. The standards are delineated into either required or addressable implementation specifications.

Under the direction of SunLink s Vice President, Technical and Compliance Services, and in conjunction with a consortium of rural hospitals, private HIPAA security consultants and HIPAA security officers at each facility, security assessments were performed, individually tailored plans to apply required or addressable solutions were implemented and a set of security policies and procedures were implemented. In addition, an

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individually tailored comprehensive disaster contingency plan was developed and adopted by each facility and a HIPAA security training program presented to all applicable personnel. SunLink believes it is in full compliance with all aspects of the HIPAA security regulations.

HIPAA National Provider Identifier

HIPAA also required 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 have fully 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.

Environmental 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 also generally are subject to various other environmental laws, rules and regulations.

SUNLINK OPERATIONS

Regulatory Compliance Program

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

Professional Liability

As part of our business, we are subject to claims of liability for events occurring in the ordinary course of operations. To cover these claims, we maintain professional malpractice liability insurance and general liability insurance in amounts, which are commercially available, that we

believe are sufficient for our operations, although some claims may exceed the scope or amount of the coverage in effect.

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

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for claims made prior to the acquisition. The recorded liability for professional liability risks includes an estimate of liability for claims assumed at the acquisition and for claims incurred after the acquisition. These estimates are based on actuarially determined amounts. In June 2004, SunLink sold Mountainside Medical Center, one of our initial six hospitals, but retained all liabilities and obligations arising from Mountainside s operations prior to the date of such sale and purchased a 7 year, claims-made, extended discovery period (tail) policy for potential professional liability claims relating to Mountainside.

Discontinued Operations and Related Contingent Obligations

Over the past 19 years we have discontinued operations carried on by our former Mountainside Medical Center and our former industrial and life sciences and engineering segments, and our former U.K. child safety, leisure marine, and housewares segments. SunLink s reserves relating to discontinued operations of these segments represent management s best estimate of our possible liability for property, product liability and other claims for which we may incur liability. These estimates are based on management s judgments using currently available information as well as, in certain instances, consultation with our insurance carriers and legal counsel. While estimates have been based on the evaluation of available information, it is not possible to predict with certainty the ultimate outcome of many contingencies relating to discontinued operations. We intend to adjust our estimates of the reserves as additional information is developed and evaluated. However, management believes that the final resolution of these contingencies will not have a material adverse impact on the financial position, cash flows or results of operations of the Company.

Beldray Limited

SunLink sold its former U.K. manufacturing subsidiary, Beldray Limited (Beldray), to two of Beldray s managers in October 2001. Beldray has since entered into administrative receivership. KRUG International U.K. Ltd. (KRUG UK), a U.K. subsidiary of SunLink, entered into a guarantee (the Beldray Lease Guarantee) at a time when it owned Beldray. The Beldray Lease Guarantee covers Beldray s obligations under a lease of a portion of Beldray s former manufacturing location. In October 2004, KRUG UK received correspondence from the landlord of such facility that the rent payment of 94,000 British pounds ($181) for the fourth quarter of 2004 had not been paid by Beldray and requesting payment of such amount pursuant to the Beldray Lease Guarantee. In January 2005, KRUG UK received further correspondence from the landlord demanding two quarterly rent payments totaling 188,000 British pounds ($362) under the Beldray Lease Guarantee. On January 7, 2005, the landlord filed a petition in the High Court of Justice Chancery Division to wind up KRUG UK under the provisions of the Insolvency Act of 1986 and KRUG UK was placed into involuntary liquidation by the High Court in February 2005. After that date, the court-appointed liquidator of KRUG UK made certain inquiries to SunLink and the subsidiary s directors regarding the activities of KRUG UK prior to the liquidation to which SunLink has responded.

On August 6, 2007, the liquidator of KRUG UK made an application in the Birmingham County Court in Birmingham, England, in which the liquidator is seeking a declaration by the court that a transfer of certain funds in 2001 from KRUG UK to SunLink in connection with the purchase of certain preferred stock of another subsidiary of SunLink and the making of a loan to SunLink, and certain forgiveness of debt to SunLink by KRUG UK was improper, among other things, as KRUG UK was then effectively insolvent and that the approval of such transfers by the then directors of KRUG UK resulted in a breach of their fiduciary duties. The liquidator seeks to have the court order the former directors or, in the alternative, the Company, to account for, repay or restore such funds plus interest to the liquidator of KRUG UK. On December 4, 2007, the case went to mediation and the mediation was adjourned pending the liquidator s investigations into the circumstances surrounding items raised by both parties. In connection with the allegations in the application of breach of fiduciary duty by the directors of KRUG UK in approving such transfer of funds, SunLink has indemnification obligations to the former directors of KRUG UK. SunLink denies any liability to KRUG UK other than to it in KRUG UK s status as a preferred stockholder and for the unpaid balance on the promissory note. SunLink, through its United Kingdom counsel, intends to vigorously defend against the liquidator s claims.

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Employee and Labor Relations

As of June 30, 2008, SunLink employed 1,370 full-time and 475 part-time persons in the U.S., none of whom are represented by a union. We believe our labor relations generally are satisfactory.

Environmental Law Compliance

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

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EXECUTIVE OFFICERS OF THE REGISTRANT

Our executive officers, as of September 22, 2008, 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	59
Mark J. Stockslager	Chief Financial Officer and Principal Accounting Officer	49
Harry R. Alvis	Chief Operating Officer	63
George D. Shaunnessy	President SunLink ScriptsRx, LLC	60
Jerome D. Orth	Vice President, Technical and Compliance Services	60
Jack M. Spurr, Jr	Vice President, Hospital Financial Operations	62

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

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

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

Harry R. Alvis has been Chief Operating Officer of SunLink Health Systems, Inc. since September 1, 2002 and Senior Vice President of Operations of SunLink Healthcare LLC since February 1, 2001. Mr. Alvis provided turn-around operational consulting services for New America Healthcare Corp. from March 2000 through January 2001. From August 1997 through August 1999, Mr. Alvis was Chief Executive Officer of River Region Health Systems in Vicksburg, Mississippi, a healthcare facility owned by Quorum Health Group, Inc. From August 1995 through August 1997, Mr. Alvis was the Chief Executive Officer of Greenview Hospital in Bowling Green, Kentucky, a healthcare facility owned by Hospital Corporation of America. From November 1987 through August 1995, Mr. Alvis was the Chief Executive Officer of Pinelake Medical Center in Mayfield, Kentucky; a facility owned by HealthTrust, Inc.

George D. Shaunnessy has been President of SunLink Homecare Services, LLC (which changed its name to SunLink ScriptsRx, LLC on August 26, 2008) since April 23, 2008. Mr. Shaunnessy was President and Chief Executive Officer of MedImagining, Inc, from 2002 to December 2007, Managing Partner and Chief Executive Officer of Affiliated Management Services, Inc., from 1997 to April 2008, and President, Chief Executive Officer and a director of Housecall Medical Resources, Inc. from 1991 to 1997. From 1978 to 1991, Mr. Shaunnessy has held executive positions with National Healthcare, Inc., Foster Medical Home Health Care, a division of Avon Products, Charter Medical Corporation and Hospital Affiliates International, Inc.

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Jerome D. Orth has been Vice President, Technical & Compliance Services for the Company since February 1, 2001. From January 1995 through January 2001, Mr. Orth was Vice President of Hospital Financial Operations for ValueMark Healthcare Systems, Inc., a privately-held owner-operator of psychiatric hospitals. From February 1987 through October 1994, Mr. Orth held various positions with Hallmark Healthcare Corporation, including Executive Director, Hospital Financial Management and Executive Director, Management Information Systems. Prior to 1987, Mr. Orth spent 12 years in various accounting, third party reimbursement and management positions with Hospital Corporation of America.

Jack M. Spurr, Jr. has been Vice President, Hospital Financial Operations for the Company since October 1, 2002. From February 1, 2001 until September 30, 2002, Mr. Spurr performed several interim financial roles for the Company. From 1978 to 2000, Mr. Spurr held financial positions with Hospital Corporation of America, Columbia Healthcare, Inc., Quorum Health Group, Inc., HealthTrust, Inc., and National Healthcare Inc.

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

SunLink has a limited operating history in the community hospital business and a limited history of profitability.

Prior to February 1, 2001, SunLink operated in different business segments. SunLink had income from continuing operations of $2,009 for the fiscal year ended June 30, 2008; $1,577 for the fiscal year ended June 30, 2007; $4,181 for the fiscal year ended June 30, 2006; $4,383 for the fiscal year ended June 30, 2005; and $1,560 for the fiscal year ended June 30, 2003. Conversely, SunLink had losses from continuing operations of $1,267 for the fiscal year ended June 30, 2004; $2,080 for the fiscal year ended June 30, 2002; $319 for the three month transitional period ended June 30, 2001; and $881 for the fiscal year ended March 31, 2001; respectively. SunLink may experience operating losses from continuing operations in the future.

SunLink s growth strategy depends in part on making successful acquisitions, via mergers, or otherwise, and on successfully integrating our recent acquisition of our pharmacy operations, which may expose SunLink to new liabilities.

As part of our growth strategy, SunLink will seek further growth through acquisitions, via mergers or otherwise, of rural and exurban healthcare businesses. We have sought to acquire and have acquired rural and exurban community hospitals, nursing homes and home health agencies, as well as other rural and exurban healthcare businesses. We may be subject to a variety of risks arising out of the acquisition of our new pharmacy business or other rural and exurban healthcare businesses. We intend, to the extent possible, to integrate the operations of acquired assets and entities with our existing organizational structure; although our pharmacy operations, like our community hospitals, will be conducted in one or more separate subsidiaries. In light of the diverse nature of our pharmacy operations and depending on the nature of other acquired entity or operations, integration of acquired operations into our present operations may present substantial difficulties. Even where material difficulties are not anticipated, there can be no assurance that we will not encounter such difficulties in integrating acquired operations with our operations, which may result in a delay or the failure to achieve anticipated synergies, increased costs and failures to achieve increases in earnings or cost savings. The difficulties of combining the operations of Carmichael s or other acquired companies may include, among other things:

unidentified liabilities of Carmichael s or of other companies SunLink may acquire or merge with;

the potential failure to achieve economies of scale or synergies sought in our new pharmacy business or in other new rural or exurban healthcare businesses;

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the possible inability to successfully integrate and manage acquired operations and personnel especially where such business is other than a community hospital or nursing home;

possible inconsistencies in standards, controls, procedures and policies, business cultures and compensation structures between us and an acquired entity;

the inability to expand sales and marketing operations;

the inability to retain existing customers and attract new customers;

the loss of or inability to attract new key employees;

the inability to achieve consolidation of corporate and administrative operations and infrastructures;

the inability to achieve integration and management of the technologies and systems of the acquired entity, including the consolidation and integration of computer information systems;

the failure to identify and eliminate redundant and underperforming operations and assets;

unexpected costs associated with the termination of assumed contractual obligations and the timing thereof;

diversion of management s attention from ongoing business concerns;

the possibility of unexpected tax costs or inefficiencies associated with the integration of the operations;

the possible need and unexpected cost to modify internal controls over financial reporting in order to comply with the Foreign Corrupt Practices Act, the Sarbanes-Oxley Act of 2002 and the rules and regulations promulgated there under; and

loss of customer goodwill.

For these reasons, we may fail to successfully complete the integration of Carmichael s or any other acquired entity, or to realize the anticipated benefits of the acquisition of Carmichael s or any other acquired entity. Actual cost savings and synergies which may be achieved from Carmichael s or any other acquired entity may be lower than we expect and may take a longer time to achieve than we anticipate. Other acquisition related risks include risks associated with higher costs or unexpected difficulties or problems with acquired assets, outdated or incompatible technologies, labor difficulties, or an inability to realize anticipated synergies and efficiencies. Whether within anticipated timeframes or at all, one or more of such acquisition-related risks, if realized, could have an adverse impact on our business, financial condition, results of operations, or operations.

Acquired businesses may have unknown or contingent liabilities, including liabilities for failure to comply with healthcare laws and regulations. Although SunLink has policies which require acquired operations to implement SunLink compliance standards, and generally will seek

indemnification from prospective sellers covering these matters, SunLink may become liable for past activities of acquired businesses. While SunLink received limited indemnification for certain potential liabilities in connection with its acquisition of Carmichael s, there is no assurance such indemnification will be collectible or that any potential liabilities will not arise after expiration of such indemnification term.

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

SunLink s growth plans require significant capital investments. Significant capital investments are required for on-going and planned capital improvements at existing hospitals and may be required in connection with future capital projects either in connection with existing properties or future acquired properties. SunLink s ability to make capital investments depends on numerous factors such as the availability of funds from operations and its credit facility and access to additional debt and equity financing. No assurance can be given that the

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necessary funds will be available. Moreover, incurrence of additional debt financing, if available, may involve additional restrictive covenants that could negatively affect SunLink s ability to operate its business in the desired manner, and raising additional equity may be dilutive to shareholders. The failure to obtain funds necessary for the realization of SunLink s growth plans could prevent SunLink from realizing its growth strategy and, in particular, could force SunLink to forego acquisition opportunities that may arise in the future. This could, in turn, have a negative impact on SunLink s competitive position.

In order to make future acquisitions SunLink may be required to incur or assume additional indebtedness. SunLink may not be able to obtain financing, if necessary, for any acquisitions that it might desire to make or it might be required to borrow at higher rates and on less favorable terms than its competitors.

Many states have enacted or are considering enacting laws affecting sales, leases or other transactions in which control of not-for-profit hospitals is acquired by for-profit corporations. These laws, in general, include provisions relating to state attorney general approval, advance notification and community involvement. In addition, state attorneys general in states without specific legislation governing these transactions may exercise authority based upon charitable trust and other existing law. The increased legal and regulatory review of transactions involving the change of control of not-for-profit entities may increase the costs required, or limit SunLink s ability, to acquire not-for-profit hospitals.

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

For the fiscal year ended June 30, 2008, our three Georgia hospitals generated approximately 45% of revenues for the year. Accordingly, any change in the current demographic, economic, competitive or regulatory conditions in the state of Georgia could have a material adverse effect on the business, financial condition, results of operations or prospects of SunLink.

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

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

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

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

licensure;

conduct of operations;

ownership 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.

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

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

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

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

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

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

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

Over the past 19 years, SunLink has discontinued operations carried on by its former industrial and life sciences and engineering segments, and U.K. child safety segments, leisure marine, and housewares segments and its former Mountainside Medical Center (by virtue of the sale of such

facility whose original facility was one of our original hospitals). Prior to our acquisition of our HealthMont subsidiaries, HealthMont had sold two hospitals and it also disposed of one additional hospital as a condition to our acquisition of HealthMont. SunLink s reserves relating to discontinued operations represent management s best estimate of possible liability

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for property, product liability, and other claims for which SunLink may incur liability. These estimates are based on management s judgments using currently available information as well as, in certain instances, consultation with SunLink s insurance carriers and legal counsel. SunLink currently does not purchase insurance policies to reduce product liability or other discontinued operations exposures and does not anticipate it will purchase such insurance in the future. While estimates have been based on the evaluation of available information, it is not possible to predict with certainty the ultimate outcome of many contingencies relating to discontinued operations. Furthermore, future events or evaluations could cause us to adjust existing reserves in connection with our operations. SunLink intends to adjust our estimates of required reserves from time to time as additional information is developed and evaluated. However, SunLink believes that the final resolution of known contingencies will not have a material adverse impact on its financial position, cash flows, or results of operations.

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

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

Risks Related to Our Healthcare Facility Operations

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

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

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

SunLink s success depends on its ability to attract and retain managers at its hospitals and related health care facilities, on the ability of hospital-based officers and key employees to manage growth successfully, and on their ability to attract and retain skilled employees. SunLink

has not had any material difficulties in attracting healthcare facility management; however, if SunLink is unable to attract and retain affective local management, the operating performance of our facilities could decline.

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

In addition to the physicians and management personnel whom SunLink employs, SunLink s operations are dependent on the efforts, ability, and experience of other healthcare professionals, such as nurses, pharmacists and lab technicians. Nurses, pharmacists, lab technicians and other healthcare professionals are generally employees of each individual SunLink hospital. SunLink s success has been, and will continue to be, influenced by its ability to attract and retain these skilled employees. A shortage of healthcare professionals in certain markets, the loss of some or all of its key employees or the inability to attract or retain sufficient numbers of qualified healthcare professionals could cause SunLink s operating performance to decline.

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

A significant portion of SunLink s revenues are derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. SunLink derived approximately 80% of its patient days and 56% of its net patient revenues from the Medicare and Medicaid programs for the year ended June 30, 2008. Previous legislative changes have resulted in, and future legislative changes may result in, limitations on and reduced levels of payment and reimbursement for a substantial portion of hospital procedures and costs.

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

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

Our community hospital operations derived approximately 44% of its net patient revenues for the fiscal year ended June 30, 2008 from private payors and other non-governmental sources who contributed approximately 20% of SunLink s patient days. Our hospitals have been affected by the increasing number of initiatives undertaken during the past several years by all major purchasers of healthcare, including (in addition to Federal and state governments) insurance companies and employers, to revise payment methodologies and monitor healthcare expenditures in order to contain healthcare costs. Initiatives such as managed care organizations offering prepaid and discounted medical services packages have adversely affected hospital revenue growth throughout the country and such packages represent an increasing portion of SunLink s admissions and outpatient revenues and have resulted in reduced revenue growth at our hospitals. In addition, private payers increasingly are attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations, referred to as PPOs. If we are unable to contain costs, especially in our hospital operations, through increased operational efficiencies and the trend toward declining reimbursements and payments continues, the results of healthcare facility segment operations and cash flow will be adversely affected and the results of our consolidated operations and our consolidated cash flow similarly likely would be adversely affected.

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

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

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The healthcare business is highly competitive and competition among hospitals and other healthcare providers for patients has intensified in recent years. Each of our hospitals operates in geographic areas where they compete with at least one other hospital that provides services comparable to those offered by our hospitals. Some of these competing facilities offer services, including extensive medical research and medical education programs, which are not offered by SunLink s facilities. Some of the competing hospitals are owned or operated by tax-supported governmental bodies or by private not-for-profit entities supported by endowments and charitable contributions which can finance capital expenditures on a tax-exempt basis and are exempt from sales, property, and income taxes. In some of these markets, SunLink s hospitals also face competition from other for-profit hospital companies, some of which have substantially greater resources, as well as other providers such as outpatient surgery and diagnostic centers.

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

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

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

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

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

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

Risk Relating to our Pharmacy Operations.

Our pharmacy operations, especially the specialty pharmacy service line of such operations, may be adversely affected by changes in government reimbursement regulations and payment levels.

Our initial pharmacy operations are expected to derive approximately 85% of their 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 our specialty pharmacy operations or that we will continue to be able to operate our specialty pharmacy operations profitably at either

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existing or at lower reimbursement rates. Likewise, we cannot assure you that the Part B CAP program will not be extended to rural or exurban areas in general or to the areas in which we operate, or may seek to operate, in particular or that we would be able to meet the qualifications to become a Part B CAP vendor either now or at any time in the future.

Our pharmacy business could be harmed by further changes in government purchasing methodologies and reimbursement rates for Medicare or Medicaid.

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

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

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

Our pharmacy operations depend on a continuous supply of key products. Any shortages of key products could adversely affect our business.

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

Our pharmacy operations are highly dependent on relationships with key suppliers and the loss of any of such key suppliers could adversely affect our business.

Any termination of, or adverse change in, our relationships with our key suppliers, or the loss of supply of one of our key products for any other reason, could have a material adverse effect on our business and results of operations. The largest supplier for our specialty pharmacy operations accounted for approximately 64% of Carmichael s total net sales in 2007. Our specialty pharmacy operations have a single source of supply for many of our key products, including one product which accounted for approximately 22% of Carmichael s total net sales in 2007. In addition, we have few long-term contracts with our suppliers. Our arrangements with most of our suppliers may be canceled by either party, without cause, on minimal notice. Many of these arrangements are not governed by written agreements.

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

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

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

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

Many government payors, including Medicare and Medicaid, have paid, or continue to pay, our pharmacy operations directly or indirectly at a percentage off a drug s average wholesale price, or AWP. We also have contracted with some private payors to sell drugs at AWP or at a percentage off AWP. AWP for most drugs 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 pharmacy operations to negotiate discounts from drug manufacturers will not be materially adversely affected by such investigations or lawsuits.

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

We face numerous competitors and potential competitors in our pharmacy operations, many of whom are significantly larger and who have significantly greater financial resources.

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

Our pharmacy operations, especially the specialty pharmacy component of such operations, may be adversely affected by industry trends in managed care contracting and consolidation.

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

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

According to an analysis of IMS Health data, spending in the U.S. in 2006 for specialty drugs was $54,000,000 or 20% of overall prescription drug spending for that year. Sales of biotech products alone a subset of specialty pharmaceuticals are estimated by the same consultant to have reached $40,000,000 in 2006. Even more conservative estimates place the size of the specialty pharmacy market between $18,000,000 and $35,000,000. Such estimates place the administrative spending for this segment at in excess of 10% of the pure cost of drug and care. A healthcare consulting firm has estimated that 95% of the 101 unique biopharmaceuticals in late-stage development in the U.S. are infusible and injectables and that there are over 800 specialty medications in phase one, phase two or phase three development. As a result, the percentage of spending for specialty pharmaceuticals may increase to more than $100,000,000 by 2010 and grow to represent more than 25 percent of total drug spending. We cannot predict whether the rate of actual future growth in product availability and spending will match projections, the extent

to which patient demand or spending for specialty drug services in rural or exurban areas will match national averages or whether government payors will provide reimbursement for new products under Medicare or Medicare on a timely basis or at all or at what rates. Adverse developments in any of these areas could have an adverse impact on our pharmacy business.

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Other Risks

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

SunLink s working capital is limited to cash generated from operations and borrowings available under our $47,000 credit facility (of which approximately $8,100 is available to borrow at June 30, 2008) and our additional debt capacity is limited. Management and the board of directors of SunLink periodically have discussed the need to raise equity in the future and periodically have considered certain transactions which might be available to SunLink to raise equity. However, SunLink has not engaged any underwriter or placement agent with respect to any potential equity offering, nor has SunLink s management made any specific proposal or recommendation to the SunLink board of directors with respect to the type of securities to be offered or the price at which any securities might be offered. Such transactions might include, among others, the sale of common shares to outsiders or the offer to existing shareholders of the right to acquire additional shares. While the board of directors has not decided to effect any equity transaction at this time, it may do so in the future. Any equity transaction could result in dilution in the value of existing shares.

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

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

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

SunLink has received a letter from the Staff of the SEC dated September 24, 2008 with respect to the Company s Current Report on Form 8-K filed September 19, 2008. The Staff has inquired as to when the Company intends to file restated financials for Carmichael s Cashway Pharmacy, Inc. The Company is currently preparing a response to the Staff.

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Item 2. ***Properties***

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

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

(1) The lease expires in March, 2019.
(2) Lease of approximately 25,000 square feet of store location, warehouse and office space. The lease expires in April 2013 and provides for a renewal of the lease for two five year terms.
(3) Lease of approximately 5,900 square feet of store location and warehouse space. The lease expires in October 2011.
(4) Lease of approximately 4,000 square feet of store location and warehouse space. The lease expires in October 2008.
(5) Lease of approximately 7,800 square feet of office space for corporate staff. The lease expires in September 2009.

Item 3. ***Legal Proceedings***

On August 6, 2007 the liquidator in an insolvency proceeding in the United Kingdom involving SunLink s former subsidiary KRUG International (UK) Limited (KRUG UK) made an application in The Birmingham County Court in Birmingham, England in which the liquidator is seeking a declaration by the court that a transfer of certain funds in 2001 from KRUG UK to SunLink in connection with the purchase of certain preferred stock of another subsidiary of SunLink, the making of a loan to SunLink, and certain forgiveness of debt to SunLink by KRUG UK Limited was improper as, among other things, KRUG UK was then effectively insolvent and that the approval of such transfers by the then directors of KRUG UK resulted in a breach of their fiduciary duties. The liquidator seeks to have the court order that the former directors or, in the alternative, SunLink , be required to account for, repay or restore such funds to the liquidator of KRUG UK. In connection with the allegations in the application of breach of fiduciary duty by the directors of KRUG UK in approving the transfer of such funds, SunLink has indemnification obligations to the former directors of KRUG UK. Each of the directors of KRUG UK and SunLink have now been served. SunLink denies any liability to KRUG UK other than to it in KRUG UK s status as a preferred stockholder and for the unpaid balance on the promissory note. SunLink, through its United Kingdom counsel, intends to vigorously defend against the liquidator s claims.

On July 13, 2006, Piedmont Healthcare, Inc. (PHI) and Piedmont Mountainside Hospital, Inc. (PMH) (collectively, Plaintiffs or Piedmont) file a Complaint in the Superior Court of Cobb County, Georgia,

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alleging breach of the Asset Purchase Agreement (the Agreement) dated as of April 9, 2004 by and among PMH, Piedmont Medical Center, Inc. (n/k/a PMI), Southern Health Corporation of Jasper, Inc. (SHJI), SunLink Healthcare LLC (formerly SunLink Healthcare Corp.), and SunLink (collectively, Defendants or SunLink) pursuant to which the Mountainside Medical Center was sold to PMH in June 2004. Specifically, Piedmont seek to have SunLink reimburse Piedmont for certain costs associated with an alleged indigent and charity care shortfall of Piedmont Mountainside Hospital (formerly Mountainside Medical Center) for the fiscal year ended June 30, 2004 demanded by the Georgia Department of Community Health (DCH). In addition, Piedmont seeks reimbursement for funds allegedly recouped from PMH by DCH in respect of Medicaid Cost Report settlements and adjustments for the reporting periods ending June 30, 2002, June 30, 2003 and May 31, 2004. Piedmont also seek a declaratory judgment to the effect that Piedmont may retain certain payments it has received from the DCH s Indigent Care Trust Fund for Disproportionate Share Hospitals. Piedmont also seeks recovery of costs and attorney s fees under the Agreement and Georgia law.

On August 11, 2006, SunLink filed an answer to the complaint asserting factual and legal defenses, along with a counterclaim. In the counterclaim, SunLink alleges that Piedmont breached the Agreement by failing to reimburse SHJI for funds paid Piedmont from the DCH s Indigent Care Trust Fund for Disproportionate Share Hospitals, which payments SunLink contend qualify as excluded assets not sold to Piedmont under the Agreement. SunLink also alleged that PMI breached its obligations to guaranty PMH s payment and performance of its obligations under the Agreement. SunLink seeks a declaratory judgment regarding the parties rights in respect of the payments made from the Indigent Care Trust Fund. Finally, SunLink seeks to recover their costs and attorney s fees under the Agreement and Georgia law. The Court has scheduled a hearing on all pending summary judgment and discovery motions for September 26, 2008.

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

Item 4. ***Submission of Matters to a Vote of Security Holders***

Not applicable.

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PART II

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

SunLink common stock is listed on the American Stock Exchange. SunLink s ticker symbol is SSY . SunLink also has publicly traded warrants which trade in the over-the-counter market under the symbol SSYMW . 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 American Stock Exchange.

	Sale Prices of SunLink Common Shares	
	High	**Low**
Fiscal 2008 (July 1, 2007 June 30, 2008)		
Fourth Quarter	$ 6.26	$ 4.75
Third Quarter	6.70	5.41
Second Quarter	6.50	5.95
First Quarter	6.55	6.00
Fiscal 2007 (July 1, 2006 June 30, 2007)		
Fourth Quarter	$ 7.35	$ 6.15
Third Quarter	7.30	6.65
Second Quarter	9.00	6.62
First Quarter	10.15	7.65

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

Dividends

SunLink does not currently pay cash dividends. SunLink intends to retain its earnings for use in the operation and expansion of its business and, therefore, does not anticipate declaring or paying 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, 2008 there were approximately 600 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, 2008 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, warrants and rights	(b) Weighted average exercise price of outstanding options, warrants and rights	(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:			
1995 Incentive Stock Option Plan	4,000	$ 5.48	0
2001 Outside Directors Stock Ownership and Stock Option Plan	82,500	$ 2.26	0
2001 Long-term Stock Option Plan	322,875	$ 3.27	0
2005 Equity Incentive Plan	781,605	$ 7.82	49,070
	1,190,980	$ 6.20	49,070
Equity compensation plans not approved by security holders:			
None	0	0	0
Total	1,190,980	$ 6.20	49,070

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Performance Graph

The following graph presents a comparison of five years cumulative total return for SunLink, the American Stock Exchange Composite Index. Peer group consists of Amsurg Corp., Community Health Systems Inc., Dynacq Healthcare Inc., Health Management Associations Inc., Lifepoint Hospitals Inc., Magellan Health Services Inc., Medcath Corp., Prezzo PLC, Rehabcare Group Inc., Tenet Healthcare Corp., and Universal Health Services Inc.

	6/03	6/04	6/05	6/06	6/07	6/08
SunLink Health Systems, Inc.	**100.00**	**230.29**	**326.97**	**410.79**	**262.24**	**199.59**
AMEX Composite	**100.00**	**128.79**	**165.82**	**204.19**	**253.70**	**243.41**
Peer Group(1)	**100.00**	**146.46**	**202.73**	**152.93**	**200.18**	**126.73**

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

Selected historical financial data presented below as of and for the fiscal years ended June 30, 2004, 2005, 2006, 2007 and 2008 have been derived from the audited consolidated financial statements of SunLink. The following financial information reflects the acquisition of our two HealthMont hospitals and Carmichael and the disposition of Mountainside Medical Center. 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)

	2004	2005	2006	2007	2008
Net revenues	$ 112,436	$ 128,732	$ 135,576	$ 143,645	$ 158,431
Earnings (loss) from continuing operations	(1,267)	4,383	4,181	1,577	2,009
Net earnings	13,425	4,540	3,909	1,396	1,616
Earnings (loss) per share from continuing operations:					
Basic	(0.20)	0.61	0.58	0.21	0.26
Diluted	(0.20)	0.57	0.53	0.20	0.26
Net earnings per share:					
Basic	2.15	0.63	0.54	0.19	0.21
Diluted	2.15	0.59	0.50	0.18	0.21
Total assets	63,152	70,113	74,303	77,843	111,624
Long-term debt, including current maturities	7,392	10,042	9,393	8,536	37,962
Shareholders equity	$ 24,904	$ 29,301	$		