SUNLINK HEALTH SYSTEMS INC
Form 10-K
September 25, 2018

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

Form 10-K

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

For the Fiscal Year Ended June 30, 2018

OR

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

For the transition period from_____to _____

Commission File No. 1-12607

SunLink Health Systems, Inc.

(Exact name of registrant as specified in its charter)

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

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

(Address of principal executive offices)

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

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

Title of each Class	**Name of each Exchange on which registered**
Common Shares without par value	**NYSE American, LLC**

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

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

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 No

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

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

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

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company
	Emerging growth company

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

At the close of business on September 25, 2018, there were 7,346,814 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, 2017 of the registrant s common shares as reported by NYSE American stock exchange amounted to $5,121,452.

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 12, 2018, have been incorporated by reference into Part III of this Report. The Proxy Statement or an amendment to this Annual Report will be filed with the Securities and Exchange Commission within 120 days after June 30, 2018.

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. Throughout these notes to the consolidated financial statements, SunLink Health Systems, Inc., and its consolidated subsidiaries are referred to on a collective basis as SunLink , we , our , ours , us or the Company. This drafting style is not meant to indicate that SunLink Health Systems, Inc. or any particular subsidiary of SunLink Health Systems, Inc. owns or operates any asset, business, or property. Trace, Parkside Ellijay, pharmacy operations and businesses described in this filing are owned and operated by distinct and indirect subsidiaries of SunLink Health System, Inc. These forward-looking statements are based on current plans and expectations and are subject to a number of risks, uncertainties and other factors which could significantly affect current plans and expectations and our future financial condition and results. These factors, which could cause actual results, performance and achievements to differ materially from those anticipated, include, but are not limited to:

General Business Conditions

- general economic and business conditions in the U.S., both nationwide and in the states in which we operate;
- increases in uninsured and/or underinsured patients due to unemployment or other conditions, higher deductibles and co-insurance, or other terms of health insurance coverage resulting in higher bad debt amounts;
- the competitive nature of the U.S. community hospital, nursing home, and pharmacy businesses;
- demographic changes in areas where we operate;
- the availability of cash or borrowings to fund working capital, renovations, replacements, expansions, and capital improvements at existing healthcare and pharmacy facilities and for acquisitions and replacement of such facilities;
- changes in accounting principles generally accepted in the U.S.; and
- fluctuations in the market value of equity securities including SunLink common shares.

Operational Factors

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

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

timeliness and amount of reimbursement payments received under government programs;

changes in interest rates under lending agreements and other indebtedness;

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

restrictions imposed by existing or future lending agreements or other indebtedness;

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 in alternative healthcare settings, 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;

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

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

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

the functionality of or costs with respect to our information systems for our Healthcare Services and Pharmacy segments and our corporate office, including both software and hardware;

the availability of and competition from alternative drugs or treatments to those provided by our Pharmacy segment; and

the restrictions, processes, and conditions relating to our Pharmacy segment imposed by pharmacy benefit providers, drug manufacturers, and distributors.

Liabilities, Claims, Obligations and Other Matters

claims under leases, guarantees, disposition agreements, and other obligations relating to discontinued operations, including claims from sold or leased Services, retained liabilities or retained subsidiaries;

potential adverse consequences of known and unknown government investigations;

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

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

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

Regulation and Governmental Activity

existing and proposed governmental budgetary constraints;

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

the decision by states in which we operate our remaining hospital (Mississippi) and two remaining nursing homes (Georgia and Mississippi) to not expand Medicaid;

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

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

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

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

Dispositions, Acquisition and Renovation Related Matters

the ability to dispose of underperforming facilities and business segments;

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

competition in the market for acquisitions of hospitals, nursing homes, pharmacy facilities, 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.

PART I

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

Overview

SunLink Health Systems, Inc., through subsidiaries, owns businesses which provide healthcare products and services in certain markets in the southeastern United States. Unless the context indicates otherwise, all references to SunLink, we, our, ours, us and the Company refer to SunLink Health Systems, Inc. and our consolidated subsidiaries. References to our specific operations refer to operations conducted through our subsidiaries and references to we, our, ours, and us in such context refer to the operations of our subsidiaries. Our business is composed of two business segments, the Healthcare Services segment and the Pharmacy segment. Our Healthcare Services segment subsidiaries own and operate an 84- bed community hospital and a 66- bed nursing home in Mississippi, a 100- bed nursing home in Georgia, an IT service company based in Georgia, and healthcare facilities, which are leased to third parties. Our Pharmacy segment subsidiary operates a pharmacy business in Louisiana with four service lines.

SunLink s executive offices are located at 900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339, and our telephone number is (770) 933-7000. Our website address is www.sunlinkhealth.com. Information contained on our website does not constitute part of this report. Certain materials we file with the SEC may also be read and copied at or through our website or at the Internet website maintained by the SEC at www.sec.gov.

Business Strategy

The business strategy of SunLink is to focus its efforts on expanding the services and improving the operations and profitability of its existing Healthcare Services and Pharmacy businesses while seeking to sell certain of its subsidiaries underperforming assets. The Company is investing in upgrades and improvements to certain of its Healthcare Services and Pharmacy businesses.

The Company has used a portion of the cash proceeds from recent dispositions of assets to pay down debt and certain other liabilities, and to repurchase common shares in tender offers completed in February and December 2017 and to make improvements to its Healthcare Services businesses.

The Company may also use existing cash, as well as any net proceeds from future dispositions, if any, to prepay debts, return capital to shareholders including through potential public or private purchases of shares, improve its existing businesses, make selective acquisitions of Healthcare Services and Pharmacy businesses and for other general corporate purposes. There is no assurance that any further dispositions will be authorized by the Company s Board of Directors or, if authorized, that any such transactions will be completed or, if completed, will result in net cash proceeds to the Company on a before or after tax basis.

The Company considers the disposition of business segments, facilities and operations based on a variety of factors in addition to under-performance, including asset values, return on investments, competition from existing and potential competitors, capital improvement needs, the prevailing reimbursement environment under various Federal and state programs (e.g., Medicare and Medicaid) and private payors, and other corporate objectives. The Company believes certain facilities in its Healthcare Services segment as well as its Pharmacy segment continue to under-perform, and the Company has engaged advisors to assist it in evaluating the possible sale of assets in its Healthcare Services and its Pharmacy business lines.

On January 11, 2018, Carmichael s Cashway Pharmacy, Inc., a wholly owned subsidiary of the Company, sold the assets of a retail pharmacy operation for approximately $410. A pre-tax gain of $183 on the sale of these assets is included in the results for the year ended June 30, 2018.

On August 27, 2018, a subsidiary of the Company entered into a contract to sell a medical office building and land for approximately $1,000. The sale is scheduled to close in the second fiscal quarter of 2019, and if it closes, the Company expects to report a pre-tax gain of approximately $450. In addition, a subsidiary of the Company has received an indication of interest to purchasing one of the Company s nursing homes for approximately $7,300 and, on August 29, 2018, entered into a non-binding letter of intent (LOI) and exclusivity agreement with a potential buyer. The non-binding LOI provides that any transaction, which is not assured to be completed, will be subject to various terms and conditions to be negotiated, including reaching agreement on a contract, satisfactory due diligence and other matters. Accordingly there can be no assurance that a transaction will be completed on any terms or at any price.

OPERATIONS

Healthcare Services

The Healthcare Services segment is composed of:

A subsidiary which owns and operates Trace Regional Hospital and Floy Dyer Nursing Home (Trace), an 84-licensed-bed acute care hospital, located in Houston, Mississippi, which includes an 18-bed geriatric psychiatry unit (GPU) and a 66-bed nursing home. This facility focuses primarily on senior healthcare services.

A subsidiary which owns and operates Parkside Ellijay, a 100- bed nursing home and rehabilitation facility (with an adult day care program) located in Ellijay, Georgia. In addition to its nursing home , Parkside Ellijay also occupies a hospital building of which the emergency department space adjacent to the nursing home and rehabilitation facilities is leased to an unaffiliated healthcare provider.

A subsidiary which owns a medical office building and unimproved land in Dahlonega, Georgia. The medical office building is currently vacant.

A subsidiary which owns a medical office building and approximately four (4) acres of land in Clanton, Alabama. A portion of the medical office is currently rented to a third party.

A subsidiary which owns approximately twelve (12) acres of unimproved land in Fulton, Missouri.

A subsidiary which owns approximately five (5) acres of unimproved land in Houston, Mississippi.

A subsidiary, Envision Health Resources (Envision), which provides information technology (IT) to outside customers and to SunLink subsidiaries.

Operating Statistics

The following table sets forth certain operating statistics for SunLink s Healthcare Services facilities, Trace and Parkside Ellijay, included in continuing operations for the periods indicated.

	2018	2017
Facilities owned or leased at end of period	2	2
Licensed hospital beds (at end of period)	84	84
Hospital beds in service (at end of period)	54	54
Licensed nursing home beds and beds in service (at end of period)	166	166
Hospital and nursing home admissions	696	573
Hospital and nursing home patient days	57,825	59,796

Sources of Revenue

Sources of Healthcare Services Revenue The following table sets forth the percentage of net revenues from various payors sources in SunLink s Healthcare Services segment for the periods indicated. The table includes Trace, Parkside Ellijay, rental income from medical office buildings and Envision.

	2018	2017
Source		
Medicare	43.1%	38.1%
Medicaid	39.9%	41.5%
Manage Care, Private and Other Sources	17.0%	20.4%
	100.0%	100.0%

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

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

Changes in the mix of the patient and resident population among reimbursement categories can significantly affect the profitability of our Healthcare Services operations. We cannot assure you that reimbursement payments under governmental and private third-party payor programs, including private Medicare supplemental insurance coverage, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Medicare reimbursement for services performed in nursing centers is subject to fixed payments under the Medicare prospective payment systems. In accordance with Medicare laws, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems under what is commonly known as a market basket update. Each year, the Medicare Payment Advisory Commission (Med PAC), a commission chartered by Congress to advise it on Medicare payment issues, makes payment policy recommendations to Congress for a variety of Medicare payment systems. Congress is not obligated to adopt Med PAC recommendations, and, based upon outcomes in previous years, there can be no assurance that Congress will adopt Med Pac s recommendations in a given year. Medicaid reimbursement rates in states in which we operate nursing centers also are based upon fixed payment systems. Generally, these rates are adjusted annually for inflation. However, these adjustments may not reflect the actual increase in the costs of providing healthcare services. In addition, Medicaid

reimbursement can be impacted negatively by state budgetary pressures, which may lead to reduced reimbursement or delays in receiving payments. Moreover, we cannot assure you that the nursing centers operated by us, or the provision of goods and services offered by us, will meet the requirements for participation in such programs.

Utilization of Local Healthcare Services Management Teams

Each of our Healthcare Services businesses is managed by a subsidiary officer who is supported by other professional personnel, including, but not limited to, a state-licensed nursing home administrator, a director of nursing, nursing assistants, licensed practical nurses, staff development coordinators, activities directors, social services directors, clinical liaisons, admissions coordinators, IT staff, and a business office manager. Staff size and composition vary depending on the size and occupancy of each healthcare facility, the types of services provided and the acuity level of the patients and residents. The nursing centers contract with physicians who provide medical director services and serve on performance improvement committees. We provide our healthcare facilities subsidiaries with centralized administrative services in certain areas including information systems, reimbursement guidance, as well as legal, finance, accounting, purchasing, human resources management, and facilities management support. The Company believes centralization of these services improves operating efficiencies, promotes the standardization of certain processes and permits the healthcare staff of our nursing centers to focus on the delivery of quality care.

Quality Assurance

Quality of care is monitored and enhanced by our clinical operations personnel, as well as family satisfaction surveys. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), passed on October 6, 2014, requires standardized assessment data for quality improvement, payment, and discharge planning purposes across the spectrum of post acute-care providers (PACs), including skilled nursing facilities.

Trace and Parkside Ellijay implement quality assurance procedures to monitor the level and quality of care provided their patients. Each has a medical director who supervises and is responsible for the quality of medical care provided and a medical advisory committee comprised of physicians who review the professional credentials of physicians applying for medical staff privileges at the facility. The medical advisory committee also reviews the quality of the logistical, medical and technological support provided to the physicians. Trace and Parkside Ellijay periodically conduct surveys of their patients, either during their stay or subsequently, to identify potential areas of improvement. Trace and Parkside Ellijay are each accredited by the JCAHO.

Healthcare Services Competition

Among the factors which we believe influence patient and customer selection in our healthcare markets are:

- The appearance and functionality of the Healthcare facilities;
- The quality and demeanor of professional staff and physicians; and
- The participation of our facility in plans which pay all or a portion of the patient s bill.

Such factors are influenced heavily by the quality and scope of services, strength of referral networks, location and the price of services.

Trace and Parkside Ellijay compete with similar senior care facilities primarily on the basis of quality of care, reputation, location, and physical appearance and, in the case of private payment residents, the charges for our services. Our Healthcare Services facilities also compete on a local and regional basis with other facilities providing similar services, including hospitals, extended care centers, assisted living facilities, home health agencies, and similar institutions. Some competitors may operate newer facilities and may provide services, including skilled nursing

services that we may not offer at our nursing centers. Our competitors include government-owned, religious organization-owned, secular nonprofit and for-profit institutions. Many of these competitors have greater financial and other resources than we do. Although there is limited, if any, price competition with respect to Medicare and Medicaid residents (since revenues received for services provided to these residents are generally based on pre-established rates), there is substantial price competition for private

payment residents. Historically our nursing centers have been located adjacent to acute care hospitals owned and operated by one of our subsidiaries. Currently, however, Parkside Ellijay operates in environment where we no longer own an adjacent hospital and such former hospital has ceased operations, although an unaffiliated healthcare provider has re-opened an emergency department adjacent to Parkside Ellijay.

Envision competes with companies which provide IT hosting, computer hardware, IT software, and IT consulting services to customers, either for fees or in connection with the sale of hardware or software. Envision does not sell hardware or software. Evasion s competitors may have larger staffs and greater resources and be subsidized by hardware or software vendors or related businesses. Price competition for IT services such as Envision provides is intense and some potential customers operate on legacy IT systems which make it difficult to change to systems which Envision is able to support.

Managed Care

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

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

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

Efforts to Control Healthcare Costs

Rural facilities, including Trace and Parkside Ellijay continue to have significant unused capacity. Average 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 nursing home care. Admissions constraints, payor pressures, and increased competition are likely to continue. Historically, facilities owned and operated by SunLink s subsidiaries have responded to such trends by upgrading facilities and equipment and adding or expanding certain inpatient and ancillary services. In addition, our facilities have reduced services and taken beds out of service in response to such trends. Currently we expect our facilities will continue to respond to such trends in a similar manner subject to the availability of capital resources and our evaluation of the continued utility of such historical responses.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010 (collectively, the Affordable Care Act or ACA) were signed into law by former President Obama on

March 23, 2010, and March 30, 2010, respectively. The ACA alters the United States health care system and is intended to decrease the number of uninsured Americans and reduce overall health care costs. The ACA attempts to achieve these goals by, among other things, requiring most Americans to obtain health insurance or pay a tax penalty, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments including disproportionate share payments, expanding the Medicare program s use of value-based purchasing programs, tying hospital payments to the satisfaction of certain quality criteria, and bundling payments to hospitals and other providers. The ACA also contains a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs, such as requiring the use of recovery audit contractors in the Medicaid program and generally prohibiting physician-owned hospitals from adding new physician owners or increasing the number of beds and operating rooms for which they are licensed. We believe the implementation or interpretation of rules and regulations or the provisions of the ACA may have and may continue to have an adverse effect on our financial condition and results of our operations, especially since the one state in which we operate our hospital has decided not to set up state exchanges and not to expand Medicaid. During the current administration, various bills have been proposed or introduced into Congress to repeal and/or replace the ACA, and various executive orders and interpretations have been issued which modify the ACA. To date, no such bills have been passed by Congress and signed into law and there can be no assurance that any such bills will become law or, if so the terms thereof.

PHARMACY OPERATIONS

The Pharmacy segment is composed of four operational areas:

Retail pharmacy products and services, consisting of retail pharmacy sales conducted in rural markets at two locations in Louisiana;

Institutional Pharmacy services consisting of the provision of specialty and non-specialty pharmaceutical and biological products to institutional clients or to patients in institutional settings, such as nursing homes, specialty hospitals, hospice, and correctional facilities;

Non-institutional Pharmacy services consisting of the provision of specialty and non-specialty pharmaceutical and biological products to clients or patients in non-institutional setting such as residential homes; and

Durable medical equipment products and services (DME), consisting primarily of the sale and rental of products for institutional clients or to patients in institutional settings and patient-administered home care.

Pharmacy Competition

There are many companies which provide one or more of the business which comprise or may compete with our Pharmacy operations. For example, home healthcare business companies, which may compete with our Pharmacy services operations, our durable medical equipment services operations or both, range in size from small entrepreneurial companies to rapidly expanding companies with strategies for national operations. Retail, institutional and DME companies range from local or regional operations to large public companies.

GOVERNMENT REIMBURSEMENT PROGRAMS

Government Reimbursement Programs Hospitals

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

Medicare Inpatient Reimbursement

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

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

DRG rate increases were 0.8%, 1.3% and 1.85% for FFY 2017, 2018, and 2019 respectively. The Balanced Budget Act of 1997 originally set the increase in DRG payment rates for future FFYs at rates that would be based on the market basket index, which in certain years have been, and in the future may be, subject to reduction factors. If the update factor does not adequately reflect increases in the cost of providing inpatient services by our subsidiary s hospital, our financial condition or results of operations could be negatively affected.

The ACA combined with the America Taxpayer Relief Act of 2012 (ATRA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MARA) made a number of changes to Medicare which include but are not limited to:

Reduction of market basket updates in Medicare payment rates for providers, to incorporate an adjustment for expected productivity gains. The market basket was reduced by 0.20% in FFYs 2015 and 2016, and by 0.75% in FFYs 2017-2019.

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

Extension of the Medicare Dependent Hospital Program until September 30, 2017.

Expansion, on a temporary basis, of the low volume hospital inpatient payment adjustment to include hospitals that are more than 15 miles from other Healthcare Services and have less than 1,600 discharges per year. The new temporary criteria were effective for FFYs 2011 through 2013 and further expanded through September 30, 2022.

Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update.

A requirement that any hospital which is not a meaningful electronic health records user will be reduced by one-half of the market basket update in FY 2016. Our subsidiary hospital did not attest as a meaningful electronic records user for FFYs 2018, 2017 or 2016.

SunLink s subsidiary hospital is an eligible hospital under one or more provisions of ACA, ATRA and MARA.

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 year 2017, the update factor was 1.65%. For calendar year 2018 the update factor was 2.0% and for 2019 the update is estimated to be 1.2%. If the update factor for current and future periods does not adequately reflect increases in SunLink s subsidiary hospital cost of providing outpatient services, our financial condition or results of operations could be negatively affected.

Medicare Bad Debt Reimbursement

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

Amounts uncollectible from specific beneficiaries are charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs was reduced by 35% beginning FFY 2014.

Medicare Disproportionate Share Payments

In addition to the standard DRG payment, the Social Security Act requires that additional Medicare payments be made to hospitals with a disproportionate share of low income patients. Beneficiary Improvement and Protection Act (BIPA) provisions 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 and is 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. Trace is classified as a disproportionate share hospital as of July 1, 2016. The Affordable Care Act provides for material reductions in Medicare DSH funding. We estimate that Medicare disproportionate share payments represented approximately 1% of our healthcare services net patient service revenues for the years ended June 30, 2018, 2017 and 2016.

Medicaid Inpatient and Outpatient Reimbursement

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

In the recent past, the state in which our subsidiary operates its hospital has initiated increased efforts to reduce Medicaid assistance payments. These efforts and reductions often are triggered by an increased effort by CMS to decrease the federal share of payments for Medicaid beneficiaries or by significant increases in program utilization and budgetary pressures on the applicable states. The federal government s percentage share of each state s medical assistance expenditures under Medicaid is determined by a formula specified in Medicaid law referred to as the Federal Medical Assistance Percentage (FMAP).

The states in which SunLink subsidiaries currently operate Healthcare services facilities have implemented initiatives to decrease the Medicaid funds paid to providers. Medicaid pays providers for inpatient services in a

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

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

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

Government Reimbursement Program Administration and Adjustments

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

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

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

In 2005, CMS began using recovery audit contractors (RACs) to detect Medicare overpayments not identified through existing claims review mechanisms. The RAC program relies on private companies to examine Medicare claims filed by healthcare providers. The RAC program was made permanent by the Tax Relief and Health Care Act of 2006. The ACA expanded the RAC program s scope to include managed Medicare and Medicaid claims, and required all states to establish programs to contract with RACs by 2011. Currently all states where our subsidiaries operate have RAC programs, and all of our Healthcare Services facilities have had requests from the various RACs to review claims.

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

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Services facilities have experienced losses in the aggregate from audit adjustments of approximately $48 and $4 for the fiscal years ended June 30, 2018 and 2017.

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

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

Government Reimbursement Programs Nursing Centers

Medicare The Medicare Part A program provides reimbursement for extended-care services furnished to Medicare beneficiaries who are admitted to nursing centers after at least a three-day stay in an acute care hospital. Covered services include supervised nursing care, room and board, social services, physical, speech, and occupational therapies, certain pharmaceuticals and supplies, and other necessary services provided by nursing centers. Medicare payments to our nursing centers are based upon certain resource utilization grouping (RUG) payment rates developed by CMS that provide various levels of reimbursement based upon patient acuity.

Medicare Part B provides reimbursement for certain physician services, limited drug coverage, and other outpatient services, such as therapy and other services, outside of a Medicare Part A covered patient stay. Payment for these services is determined according to the Medicare Physician Fee Schedule (MPFS). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established Medicare physician reimbursement updates with quality and value measurements and participation in alternative payment models.

In 2006, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Part D) implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit. Under Medicare Part D, dual-eligible patients have their outpatient prescription drug costs covered by this Medicare benefit, subject to certain limitations. Most of our nursing center patients are dual-eligible patients who qualify for the Medicare drug benefit. Accordingly, Medicaid is no longer a primary payor for the pharmacy services provided to these patients.

On April 1, 2014, the Protecting Access to Medicare Act (PAMA) was enacted, which directed CMS to create a value-based purchasing initiative applicable to nursing centers beginning October 1, 2018. The initiative focused on a preventable hospital readmission measure to be provided on or before October 1, 2015 and corresponding preventable hospital readmission rates to be provided on or before October 1, 2016. Nursing centers will be ranked according to performance on this preventable hospital readmission rate, with corresponding incentive payments based upon such ranking. CMS also will reduce the Medicare per diem rate by 2% beginning October 1, 2018 in connection with the launch of this initiative.

Federal legislation has imposed various limitations and administrative requirements on Medicare reimbursement, including therapy caps, automatic and specific payment reductions, pre-payment manual claim reviews and other efforts to limit reimbursement. CMS also provides periodic reimbursements updates, including market basket updates which are often reduced by various factors.

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Medicaid Medicaid is a state-administered program financed by state funds and matching federal funds. The program provides for medical assistance to the indigent and certain other eligible persons. Although administered under broad federal regulations, states are given flexibility to construct programs and payment methods consistent with their individual goals. Accordingly, these programs differ in many respects from state to state.

Our subsidiary nursing centers provide Medicaid-covered services consisting of nursing care, room and board, and social services to eligible individuals. In addition, states may at their option cover other services such as physical, occupational, and speech therapies, and pharmaceuticals. Medicaid programs also are subject to statutory and regulatory changes, administrative rulings, interpretations of policy by the state agencies, and certain government funding limitations, all of which may materially increase or decrease the level of program payments to our subsidiary nursing centers. We believe that the payments under many of these programs may not be sufficient on an overall basis to cover the costs of serving certain patients participating in these programs. In addition, many states are experiencing budgetary pressures which have resulted in further reductions to Medicaid payments to our nursing centers.

There continue to be legislative and regulatory proposals that would impose further limitations on government and private payments to providers of healthcare services. Many states are considering or have enacted measures that are designed to reduce their Medicaid expenditures and to make certain changes to private healthcare insurance. As states face budgetary issues, we anticipate further pressure on Medicaid rates that could negatively impact payments to our nursing centers.

In addition, some states seek to increase the levels of funding contributed by the federal government to their Medicaid programs through a mechanism known as a provider tax. Under these programs, states levy a tax on healthcare providers, which increases the amount of state revenue available to expend on the Medicaid program. This increase in program revenues increases the payment made by the federal government to the state in the form of matching funds. Consequently, the state then has more funds available to support Medicaid rates for providers of Medicaid covered services. However, states may not necessarily use these funds to increase payments to nursing center providers. Provider tax plans are subject to approval by the federal government. Although some of these plans have been approved in the past, we cannot assure you that such plans will be approved by the federal government in the future.

Nongovernment payments Although our nursing centers seek to maximize the number of nongovernment payment residents admitted to our nursing centers, including those covered under private insurance and managed care health plans, nongovernment payment residents in our nursing centers are limited. Nongovernment payment residents typically have financial resources (including insurance coverage) to pay for their services and do not rely on government programs for support. It is important to our business to establish relationships with commercial insurers, managed care health plans, and other private payors and to maintain our reputation with such payors as a provider of quality patient and resident care. We negotiate contracts with purchasers of group healthcare services, including private employers, commercial insurers, and managed care companies. Most payor organizations attempt to obtain discounts from established charges. We focus on demonstrating to these payors how our services can provide them and their customers with the most viable pricing arrangements in circumstances where they may otherwise be faced with funding treatment at higher rates at other healthcare providers. The importance of obtaining contracts with commercial insurers, managed care health plans and other private payors varies among markets, depending on such factors as the number of commercial payors and their relative market strength. Failure to obtain contracts with certain commercial insurers and managed care health plans or reductions in lengths of stay or payments for our services provided to individuals covered by commercial insurance could have a material adverse effect on our business, financial position, results of operations, and liquidity.

Government Reimbursement Programs Pharmacy

The operations of our Pharmacy segment are subject to certain rules implemented by the Medicare Modernization Act (MMA) and, in the future, may be subject to other rules previously implemented by MMA with respect to urban providers. Regulations implementing cost containment mandates under MMA reduced the reimbursement for healthcare providers in urban areas for a number of products and services which are also provided by our pharmacy operations and established a competitive bidding program for certain durable medical equipment provided under Medicare Part B in urban areas. Competitive bidding is intended to further reduce reimbursement for certain products and will likely decrease the number of companies permitted to serve Medicare beneficiaries in the competitive bidding areas (CBAs). CMS had planned to implement the competitive bidding program for Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) products and services with the goal of offering beneficiaries access to quality with lower out-of-pocket costs. Prior to January 1, 2016, our Pharmacy segment operations were exempted under the Deficit Reduction Act of 2005 from the proposed competitive acquisition program for DMEPOS. However, on October 31, 2014, the CMS released Final Rule 1614-F, Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, which, in conjunction with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Social Security Act, established the methodology to expand competitive bidding to non-bid areas and to implement national price adjustments to payments for DMEPOS and enteral nutrition products previously paid under fee schedules. Under these rules and the resulting expansion plan, CMS applied competitive bidding prices to claims for DMEPOS and enteral nutrition products in previously non-bid areas currently covered in Rounds One and Two of the Competitive Bidding Program (CBP). An un-weighted average of all of the single payment amounts from the CBAs in each of the eight distinct CBAs was used to determine a regional single payment amount (RSPA) for each covered item in each CBA. From January 1, 2016 to June 30, 2016, reimbursement rates for affected product categories were reduced significantly, based on the sum of 50 percent of the current unadjusted fee schedule amount plus 50 percent of the RSPAs. Then, on July 1, 2016, the reimbursement rates were reduced further too fully implement the bidding-derived rates (i.e., 100% of the adjusted fee schedule amount, based on regional competitive bidding rates). The January 1, 2017 implementation of the 21st Century Cures Act (Cures Act), enacted