SUNLINK HEALTH SYSTEMS, INC.

900 Circle 75 Parkway, Suite 1120
Atlanta, Georgia 30339

September 27, 2019

Dear Shareholder:

You are cordially invited to attend the Annual Meeting of Shareholders, which will be held at 10:00 a.m., local time, on Monday, November 11, 2019, at the Hyatt House Hotel, 3595 Cumberland Blvd. SE, Atlanta, Georgia 30339.

The accompanying Notice of the Annual Meeting and Proxy Statement contain detailed information concerning the matters to be considered and acted upon at the meeting. The Company's 2019 Annual Report to Shareholders is also enclosed.

We hope you will be able to attend the meeting.

Shareholders of record at the close of business on September 23, 2019 are entitled to vote at the annual meeting. Whether or not you plan to attend the meeting, we encourage you to read the Proxy Statement and vote as soon as possible. You may vote:

- by following the Internet voting procedures described in these Proxy Materials;
- by following the telephone voting procedures described in these Proxy Materials; or
- by executing and returning the enclosed proxy card at your earliest convenience to ensure representation at the meeting.

Whether or not you plan to attend the meeting, please vote via the internet or telephone or execute and return the enclosed proxy card at your earliest convenience to ensure representation at the meeting. If you are providing a proxy and you later find you can attend the meeting, you may, if you wish, withdraw your proxy and vote in person.

We appreciate your support of SunLink.

Sincerely,

ROBERT M. THORNTON, JR.

President and Chief Executive Officer

SUNLINK HEALTH SYSTEMS, INC.

900 Circle 75 Parkway, Suite 1120
Atlanta, Georgia 30339

NOTICE OF 2019 ANNUAL MEETING OF SHAREHOLDERS
TO BE HELD ON NOVEMBER 11, 2019

To the Shareholders of
SUNLINK HEALTH SYSTEMS, INC.:

The Annual Meeting of Shareholders of SUNLINK HEALTH SYSTEMS, INC. will be held at 10:00 a.m., local time, on Monday, November 11, 2019, at the Hyatt House Hotel, 3595 Cumberland Blvd. SE, Atlanta, Georgia 30339, for the purpose of considering and voting upon:

1. The election of three (3) members of the board of directors named in the Proxy Statement for a term of two (2) years, and until their respective successors are elected and qualified; and
2. The ratification of the appointment of Cherry Bekaert LLP as our Independent Registered Public Accounting Firm for Fiscal Year 2020.
3. The ratification of the extension of the "Final Expiration Date" under the Company's Tax Benefits Preservation Rights Plan (the "Rights Plan") with American Stock Transfer & Trust, LLC, as Rights Agent, which Rights Plan was previously entered into on September 29, 2016.

To transact such other business that may properly come before the meeting. Except with respect to the procedural matters incident to the conduct of the annual meeting, we are not aware of any other business to be brought before the annual meeting.

Holders of record of the common shares of SunLink at the close of business on September 23, 2019 will be entitled to notice of and to vote at the meeting. You may vote by the internet, telephone or mail to the extent described in the Company's Proxy Statement. Internet and telephone voting for holders of record will conclude on the Sunday prior to the meeting.

Audited financial statements for the year ended June 30, 2019 and the related Management's Discussion and Analysis of Financial Condition and Results of Operations are included in our Form 10-K, such portions of which are also contained in the Annual Report included with this communication.

To attend the annual meeting you must have valid proof of identification and other proof of beneficial ownership of SunLink Health Systems, Inc. common shares (such as a brokerage statement reflecting your share ownership) as of September 23, 2019.

Whether or not you expect to be present, please vote via the internet or telephone or mark, sign, date, and return the enclosed proxy promptly in the envelope provided. Giving the proxy will not affect your right to vote in person if you attend the meeting.

By order of the Board of Directors of
SunLink Health Systems, Inc.

/s/ Theresa Mota

Theresa Mota
Secretary
September 27, 2019

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SUNLINK HEALTH SYSTEMS, INC.
900 Circle 75 Parkway, Suite 1120
Atlanta, Georgia 30339

PROXY STATEMENT
FOR 2019 ANNUAL MEETING OF SHAREHOLDERS

GENERAL INFORMATION

We are providing these Proxy Materials to you in connection with the solicitation of proxies by the board of directors of SunLink Health Systems, Inc. for the 2019 Annual Meeting of Shareholders and for any adjournment or postponement of the annual meeting. In this Proxy Statement, we refer to SunLink Health Systems, Inc. as "SunLink," the "Company," "we" or "us."

We are holding the annual meeting at 10:00 a.m. local time, on Monday, November 11, 2019, at the Hyatt House Hotel, 3595 Cumberland Blvd. SE, Atlanta, Georgia 30339.

These Proxy Materials include:

- Our Proxy Statement for the annual meeting; and
- Our 2019 Annual Report to Shareholders, which includes our audited consolidated financial statements.

All shareholders will have the ability to access the Proxy Materials on a website referred to in these Proxy Materials.

We intend to mail this Proxy Statement and a proxy card to shareholders starting on or about September 30, 2019.

SMALLER REPORTING COMPANY

The SEC has adopted rules allowing smaller reporting companies to tailor their disclosure to reduce costs. Because the Company qualifies as a "smaller reporting company" under the SEC rules, the Company has elected to prepare this Proxy Statement and other annual and periodic reports as a "smaller reporting company" consistent with rules of the SEC. Under the scaled disclosure obligations, the Company is not required to provide, among other things, a Compensation Discussion and Analysis and certain other tabular and narrative disclosures relating to executive compensation.

ABOUT THE MEETING

At our annual meeting, our shareholders will act upon the matters outlined in the accompanying notice of meeting. The scheduled matters to be acted upon at the 2019 annual meeting are the election of three (3) members of the board named in the Proxy Statement, and the ratification of the appointment of Cherry Bekaert LLP as our independent registered public accounting firm for fiscal year 2020. In addition, our management will report on our performance during fiscal year 2019.

VOTING INFORMATION

All shares represented by properly executed proxies received by the board pursuant to this solicitation will be voted in accordance with the shareholder's directions specified in the applicable voting instructions or proxy card. If no directions have been specified during internet or telephone voting or by marking the appropriate places on the physical proxy card, the shares will be voted in accordance with the board's recommendations which are:

- FOR the election of each of the director nominees as directors of the Company for a term of two (2) years, and until their successors are elected and qualified.
- FOR the ratification of the appointment of Cherry Bekaert LLP as the Company's Independent Registered Public Accounting Firm for Fiscal Year 2020.
- FOR the ratification of the extension of the "Final Expiration Date" for the Company's Rights Plan to September 29, 2024.

A shareholder signing and returning a proxy has power to revoke it at any time prior to its exercise by delivering to the Company a later-dated proxy or by giving notice to the Company in writing or at the meeting, but without affecting any vote previously taken.

Record Date

You may vote all shares that you owned as of September 23, 2019, which is the record date for the annual meeting. On September 23, 2019, we had 6,986,855 common shares outstanding. Each common share is entitled to one (1) vote on each matter properly brought before the meeting.

Ownership of Shares

If your shares are registered directly in your name, you are the holder of record of these shares and we are sending these Proxy Materials directly to you. As the holder of record, you have the right to give your proxy directly to us, give your voting instructions by telephone or by the Internet directly to us, or vote in person at the annual meeting. If you hold your shares in a brokerage account or through a bank or other holder of record, you hold the shares in "street name," and your broker, bank or other holder of record is sending these Proxy Materials to you. As a holder in street name, you have the right to direct your broker, bank or other holder of record how to vote by filling out a voting instruction form as provided to you by your broker or other person who is the holder of record, or if such internet or telephone access is provided to you by such holder of record, by following the directions to provide your instructions to the record holder via the internet or by telephone. Regardless of how you hold your shares, we invite you to attend the annual meeting.

Electronic Availability

In compliance with the proxy rules promulgated under the Securities Exchange Act of 1934, as amended (the "Exchange Act") by the United States Securities and Exchange Commission ("SEC"), our Proxy Statement and Annual Report to Shareholders are available over the internet at *www.proxyvote.com*, a website established specifically for access to such materials. Such materials are also available on the Company's website at *www.sunlinkhealth.com*.

How to Vote

Your Vote Is Important. We encourage you to vote promptly. Internet and telephone voting is available through 11:59 p.m. local time on Sunday, November 10, 2019 for all shares held of record. Depending on whether you are a record holder of your shares, or whether you hold your shares in "street name," you may vote by any of the means described below.

Voting Procedures for Holders of Record

If you are a holder of record, you may vote your shares by any of the following methods:

By Internet: If you are a holder of record you can vote your shares by using the internet. Your proxy card indicates the website you need to access for internet voting. Holders of record may vote on the internet 24 hours a day. Our internet voting system has easy-to-follow instructions and allows record holders to confirm that the system has properly recorded their votes. If you vote by internet, you do not need to return your proxy card.

By Telephone: If you are a holder of record located in the U.S., you can also vote your shares by calling the toll-free telephone number provided on your proxy card. Holders of record may vote by telephone 24 hours a day. As with internet voting, you will be able to confirm that the system has properly recorded your votes. If you vote by telephone, you do not need to return your proxy card.

By Mail: If you are a holder of record, you can vote by marking, dating and signing your proxy card and returning it by mail in the enclosed postage-paid envelope.

At the Annual Meeting: You may vote in person at the Annual Meeting. If you vote your shares now, it will not limit your right to change your vote at the Annual Meeting if you attend in person.

Voting Procedures for Beneficial Holders

If you hold your shares in "street name," you may vote your shares by any of the following methods:

By Internet/Telephone: The availability of internet and telephone voting for beneficial owners will depend on the voting processes of your broker, bank or other holder of record. Therefore, we recommend that you follow the voting instructions in the materials you receive from your broker, bank or other holder of record.

By Mail: If you hold your shares in street name, please complete and mail the voting instruction card you receive from your broker, bank or other holder of record.

At the Annual Meeting: You may vote in person at the Annual Meeting. If you hold your shares in street name, you must obtain a proxy, executed in your favor, from the holder of record if you wish to vote your shares in person at the Annual Meeting.

Broker Vote on Election of Directors, Routine and Non-Routine Proposals—A "broker non-vote" occurs when a broker holding your shares in street name does not vote on a particular matter because you did not provide the broker voting instructions and the broker lacks discretionary voting authority to vote the shares because the matter is non-routine or fails to exercise such authority. New York Stock Exchange (NYSE) Rule 452 and Section 402.8 of the NYSE Listed Company Manual which regulate broker voting in connection with certain listed companies, including companies listed on the NYSE American, LLC exchange ("NYSE

American exchange"), prohibit broker discretionary voting on a variety of matters, including, but not limited to, the election of directors for shares held in client accounts when the broker has not timely received voting instructions from the client as well as on matters related to executive compensation.

Rule 451 and Rule 452(19) of the NYSE provides that if you fail to instruct the record owner how to vote by the tenth day before the meeting, the record owner is not permitted to vote your shares in its discretion on your behalf for the election of directors even in uncontested elections or on matters related to executive compensation, but is permitted to vote your shares in its discretion on your behalf on specified routine items.

NYSE American exchange rules also determine whether other proposals presented at the shareholder meetings are routine or not routine. If your holdings of our common shares are held in street name, under the rules of the NYSE your broker or other nominee may vote your shares on certain routine matters, if you do not provide such record holder with voting instructions. The ratification of the selection of our independent registered public accountants is considered a routine matter upon which brokerage firms and other nominees may vote on behalf of the beneficial owners if no voting instructions are provided.

While banks and brokers have historically cast their votes on routine items in support of management's recommendations in the absence of instructions from their clients, some firms are now casting uninstructed votes in the same proportion as their clients' instructed votes, giving, in effect, investors who provide voting instructions to brokers an opportunity to disproportionately influence the outcome of proxy voting.

If you want to ensure that your shares are voted in accordance with your wishes on Proposals 1, 2 and 3, you should complete and return your voting instruction form before November 1, 2019.

Revocation of Proxies: All shares that have been properly voted and whose votes have not been revoked will be voted at the meeting. If you sign and return your proxy card without any voting instructions, your shares will be voted as the board recommends.

Holders of Record

You can revoke your proxy at any time before your shares are voted if you: (1) submit a written revocation to our Secretary; (2) submit a later-dated proxy; (3) provide subsequent internet or telephone voting instructions within the time permitted for such voting methods; or (4) vote in person at the meeting.

Beneficial Holders

If you are a beneficial holder you can revoke your proxy or voting instructions at any time before your shares are voted if you (1) cause the record holder to submit a written revocation to our Secretary; (2) cause the record holder to submit a later dated proxy if you timely provide updated voting instructions to such holder by mail or if provided by the record holder by internet or telephone voting; or (3) vote your shares in person at the annual meeting through a later-dated proxy, executed in your favor, from the holder of record.

Quorum and Required Vote

Quorum: We will have a quorum and will be able to conduct the business of the annual meeting if the holders of a majority of the shares that are entitled to vote are present at the meeting, either in person or by proxy.

Votes Required: To elect directors a plurality of the votes cast is required. To ratify the appointment of Cherry Bekaert LLP as the Company's Independent Registered Public Accounting Firm for Fiscal 2020 and to ratify the extension of the Final Expiration Date for the Rights Plan to September 29, 2024, a majority of votes cast is required.

How We Count Votes: Abstentions will be counted for purposes of determining the presence or absence of a quorum. In the case of Proposal 1 (Election of Directors), Proposal 2 (Ratification of the Selection of Independent Registered Public Accountants), and Proposal 3 (Ratification of extension of Final Expiration Date for the Rights Plan to September 29, 2024) abstentions will not change the number of votes cast for or against these proposals.

Other Business; Adjournment and Postponements

We are not aware of any other business to be acted upon at the annual meeting. If, however, other matters are properly brought before the annual meeting, your proxies will have discretion to vote or act on those matters according to their best judgment.

Any adjournment of the annual meeting may be made from time to time by approval of the holders of a majority of the voting shares held by shareholders present in person or by proxy at the annual meeting, whether or not a quorum exists, without notice other than by an announcement made at the annual meeting. The record date for the annual meeting will continue to be the record date for all adjournments of such meeting unless the board sets a new record date in which event notice of the record date and of the date to which the meeting has been adjourned will be given in accordance with Ohio law and applicable rules of the NYSE American exchange.

If a quorum is not present at the annual meeting, shareholders may be asked to vote on a proposal to adjourn or postpone the annual meeting in order to allow the solicitation of additional proxies. If a quorum is present at the annual meeting, a shareholder vote may be taken on any of the proposals in this Proxy Statement prior to any such adjournment if there are sufficient votes for approval of such proposal. If a quorum is present at the annual meeting but there are not sufficient votes at the time of the annual meeting to approve one or more proposal(s), shareholders may also be asked to vote on a proposal to adjourn or postpone the annual meeting in order to allow the solicitation of additional proxies with respect to any proposals on which action is not taken prior to adjournment of the meeting.

CORPORATE GOVERNANCE

Our business is managed by the Company’s employees under the direction and oversight of the board of directors. Except for Mr. Thornton, none of our board members is an employee of the Company. The board limits membership on the audit committee and the executive compensation committee (referred to in this Proxy Statement as the “compensation committee”) to independent non-management directors. We keep board members informed of our business through discussions with management, materials we provide to them, visits to our offices and facilities, and their participation in board and board committee meetings.

The board has adopted charters for the standing board committees (other than the executive committee), resolutions governing the process for identification and nomination of candidates for the board, and the Company’s code of ethics, known as the SunLink Health Systems, Inc. Code of Conduct. These documents, together with the Company’s Articles of Incorporation and Code of Regulations, provide the framework for the governance of the Company. Our Code of Conduct is applicable to our directors and our employees, including our principal executive officer and principal financial officer. Members of our board are required to certify compliance with our Code of Conduct. Any amendment to or waiver of our Code of Conduct for any board member, our chief executive officer, our chief financial officer or any other executive officer as well as our comptroller and any other similar accounting officer will be disclosed on our website, *www.sunlinkhealth.com*.

A complete copy of the charters of the board committees, the resolutions governing the process for identification and nomination of candidates for the board and the Code of Conduct for employees, as in effect from time-to-time, may be found on the Company’s website at *www.sunlinkhealth.com*. Copies of these materials are also available to shareholders without charge upon written request to the Secretary of the Company.

Summary of the Corporate Governance Principles

Board and Leadership Structure

The Company's Code of Regulations provide for a minimum of six (6) and a maximum of eight (8) directors, as determined by the board from time-to-time. The Company currently consists of six (6) directors.

Our Company is led by Mr. Robert M. Thornton, Jr. who has served as chief executive officer and chairman of the board since 1998. We combine this traditional leadership structure with a board structure in which our non-management directors meet regularly outside of the presence of Mr. Thornton. We believe that this structure currently works best for the Company by providing us with the benefits of a single person setting the tone and having primary responsibility for managing our operations and provides clear leadership. At the same time, by having a board which is composed mainly of independent directors, including former CEOs, individuals with healthcare industry operating experience, and diverse other talents, we believe that we have created a board that is collegial, well versed in board processes and the duties of the committees on which they sit, and well engaged in their responsibilities. The board believes its members have no reticence about forcefully expressing their views while at the same time fully and fairly considering the views of their fellow directors, and that the members of the board have the experience and ability to critically evaluate the performance of our Chairman and CEO in implementing the strategic, as well as day to day, goals of the Company. Although the board periodically evaluates alternative board governance models and refinements to the existing structure, it believes, after assessing the current service of the Company's Chairman and CEO and the current composition of the board, that the current board leadership structure is appropriate for the Company.

Independence

The board is required to consist of a majority of independent, non-management directors who meet the criteria for independence required by the NYSE American exchange. Under such rules, a director is independent if he or she does not have a material relationship that would interfere with the exercise of independent judgment in carrying out the responsibilities of a director. Our board annually evaluates each board member's independence.

The board has determined that, as of September 23, 2019, five (5) of the Company's six (6) incumbent directors are independent under these guidelines: Messrs. Baileys, Burleson, Ford, Turner and Mills. Mr. Thornton, as a management director, also participates in the board's activities and provides valuable insights and advice. Each member of our audit and compensation committees is an independent director both under the general definition for board independence as well as any separate independence criteria for service on the applicable committee whether required by the SEC, the NYSE American exchange or SunLink. Independence requirements for committee service are set forth in the respective committee charters.

The non-management directors meet periodically in executive session without the management director present. The executive sessions of non-management directors are presided over by the director who is the chairperson of the committee responsible for the issue being discussed. General discussions, such as the review of the Company's overall performance, are presided over by the chairperson or a director elected by a majority of the non-management directors.

Role of the Board in Risk Oversight

The business of the Company is managed by the Company's employees under the direction and oversight of the board. Among the oversight activities of the board is the broad oversight of risk. Risk is inherent in virtually every business activity. Accordingly, the board's primary role with respect to risk is to ensure that the Company's management implements appropriate procedures designed to identify and, where possible, quantify and/or mitigate risks. The board administers its risk oversight function both at a board level and through its various committees. Our board committees consider, among other things, risk issues within their areas of responsibilities. For example: The audit committee oversees the accounting and financial reporting process, the adequacy of our risk-related internal financial controls, internal audit, the impact of risks on our current financial position, and related compliance matters. The compensation committee oversees the annual performance evaluations of executive management, succession planning, and the evaluation of risks that may be implicated by the Company's compensation structure. The responsibilities of certain individual committees are discussed in greater detail elsewhere in this Proxy Statement.

Director Share Ownership

SunLink believes that each director should have a personal investment in the Company. Each outside director (or future outside director, as the case may be) is required to own at least one thousand (1,000) common shares of SunLink. Each outside director (or future outside director, as the case may be) must maintain ownership of such number of common shares until such outside director ceases to serve as a member of the board. Each of our incumbent directors has complied with such ownership requirement since at least July 1, 2008.

Annual Meeting Attendance

Although we do not have a formal policy regarding attendance by members of the board at our annual meeting of shareholders, the board encourages all of its members to attend the annual meeting of shareholders. In November 2018, all director nominees and all then directors were personally present at the annual meeting of shareholders, except Mr. Mills and Ms. Brenner. Ms. Brenner did not stand for re-election at the 2018 annual meeting.

Communications By and With Directors

In connection with the proper discharge of their duties, our independent non-management directors have access to individual members of management or to other employees of the Company on a confidential basis. Likewise, in connection with the discharge of their duties, non-management directors—as authorized by the board or a committee thereof—also have access to Company records and files, and our directors may contact other directors without informing Company management of the purpose or even the fact of such contact.

Shareholders may communicate with the board, board committees, non-employee directors as a group, and individual directors by submitting their communications in writing to SunLink Health Systems, Inc., 900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339 Attention: Corporate Secretary. Any communication should contain (i) a representation that the shareholder is a holder of record of our common shares; (ii) the name and address, as they appear on our books, of the shareholder sending the communication; and (iii) the number of our common shares that are beneficially owned by such shareholder.

Our corporate secretary will forward communications to the intended recipients unless the communication is unduly hostile, threatening, illegal or similarly inappropriate, in which case our corporate secretary has the authority to discard the communication or to take appropriate legal action regarding the communication. Similarly, unsolicited advertisements or invitations to conferences or promotional material, in the discretion of our corporate secretary or her designee, may not be forwarded to the directors.

Related Party Transactions

The Company is subject to a variety of prohibitions on, or approval procedures with respect to, related party transactions.

First, the Company is subject to certain of the NYSE American exchange requirements which require shareholder approval of certain related party transactions. Second, the Company's Code of Conduct prohibits related party transactions which could give rise to a conflict of interest including, but not limited to, employment by third parties that do business with the Company; conducting business, not on behalf of the Company, with the Company's vendors, suppliers, and contractors; representing the Company in any transaction where such person representing the Company has a substantial personal interest; disclosure or use of confidential or inside information about the Company for personal gain; competition with the Company in any purchase, sale or ownership of property, property rights or interests; performing services for vendors or competitors of the Company; service on any board of directors or trustees that might conflict with the Company's interests and; the acceptance of any faculty or speaker positions and any honoraria in connection therewith. A related party transaction must be approved by the Company's compliance committee, or, in the case of a member of the board and/or an executive officer, such related party transaction must be approved by the board's audit committee, with such action reported to the Company's independent directors. To assist in identifying related party transactions, each director and executive officer is required, annually, to submit a Conflict of Interest Disclosure Statement. We have not adopted formal standards for the approval of related party transactions, but instead the compliance committee or the board reviews these transactions on a case-by-case basis and may approve such transactions that are in, or not inconsistent with, the best interests of the Company and its shareholders.

BENEFICIAL OWNERSHIP OF OUR COMMON SHARES

Common Shares Owned By Management and Certain Beneficial Owners

The following table sets forth, as of September 23, 2019 (unless otherwise indicated in the footnotes), certain information with respect to our common shares owned beneficially by each director, by each nominee for election as a director, by each "named executive officer," by all directors, nominees and named executive officers as a group and by each person known by us to be a beneficial owner of more than 5% of our outstanding common shares. Except as noted in the footnotes, each of the persons listed has sole investment and voting power with respect to the common shares included in the table.

	Common Shares Beneficially Owned As of September 23, 2019	
Name[1]	Number[2]	% of Class[3]
Robert M. Thornton, Jr. Director, Chairman, President and Chief Executive Officer	643,343[4]	9.1
Mark J. Stockslager Chief Financial Officer and Principal Accounting Officer	160,926[5]	2.3
Byron D. Finn President, SunLink ScriptsRx, LLC	0	*
Dr. Steven J. Baileys Director	962,844[6]	13.7
Gene E. Burleson Director	127,243[7]	1.8
C. Michael Ford Director	94,122[7]	1.3
Howard E. Turner Director	437,577[7]	6.2
Christopher H. B. Mills Director	856,546[7][8]	12.2
Nicholas Berggruen Charitable Trust	374,852[9]	5.4
Wittenberg Investment Management, Inc.	716,549[10]	10.3
Directors, Nominees and Executive Officers as a group (8 persons)	3,282,601[11]	44.0

* Less than 1%.

(1) The address of the named director or officer is c/o SunLink Health Systems, Inc., 900 Circle 75 Parkway, Suite 1120, Atlanta, Georgia 30339.

(2) Information with respect to beneficial ownership is based upon information furnished by each owner unless otherwise indicated. None of the shares beneficially owned by the named officers and directors are the subject of any pledge agreement or arrangement or margin account.

(3) The percent of outstanding common shares owned is determined by assuming that in each case the person only, or group only, exercises his, her or its rights to purchase all of the common shares underlying options held by such person or group that are exercisable as of September 23, 2019, or that will become exercisable within 60 days after that date and based on 6,986,855 outstanding shares as of such date.

(4) Includes 120,000 shares that may be acquired under options exercisable within 60 days of September 23, 2019. Also includes 203,584 shares owned by CareVest Capital, LLC ("CareVest"). Mr. Thornton owns 100% of the outstanding voting interests of CareVest.

(5) Includes 60,000 shares that may be acquired under options exercisable within 60 days of September 23, 2019.

(6) Includes 60,000 shares that may be acquired under options exercisable within 60 days of September 23, 2019. Also includes 574,602 shares held by Beilihis Investments, LLC ("Beilihis"), which is a private investment firm. Dr. Baileys is the managing member of Beilihis.

(7) Includes 60,000 shares that may be acquired under options exercisable within 60 days of September 23, 2019.

(8) Includes aggregate holdings under a joint filing on a Schedule 13D dated October 12, 2018 and filed with the SEC on October 15, 2018 by Harwood Capital LLP, formerly known as North Atlantic Value, LLP ("*Harwood Capital*"), Christopher H. B. Mills, and North Atlantic Smaller Companies Investment Trust Plc ("*NASCIT*") (collectively, the "*Group*"). The following information is based solely on such filing and subsequent information provided by Mr. Mills. Harwood Capital is a limited liability partnership organized under the laws of England with its principal office and business at 6 Stratton Street, London W1J 8LD England. Harwood Capital is a firm authorized by the United Kingdom's Financial Conduct Authority and its principally engaged in the business of investment management of active value and private equity investments, as well as to its private clients. Mr. Mills is a British citizen whose business address is 6 Stratton Street, London W1J 8LD England. His principal employment includes service as director and chief executive of NASCIT and as chief investment officer and member of Harwood Capital. NASCIT is a corporation organized under the laws of England with its principal office and business at 6 Stratton Street, London W1J 8LD England. NASCIT is a publicly-held investment trust company. Mr. Mills is director and chief executive of NASCIT and Harwood Capital acts as manager. The aggregate number of the outstanding shares reported by the Group in such Schedule 13D to be beneficially owned by each member and, to the knowledge of the Group, by each other person who may be deemed to be a member of the Group was as follows (shares held by Harwood Capital included 745,402 shares held by NASCIT and 51,144 shares held by certain private clients of Harwood Capital) and excluded options held by Mr. Mills:

Group Member	Aggregate Number of Shares	Number of Shares: Sole Power to Vote	Number of Shares: Shared Power to Vote	Number of Shares: Sole Power to Dispose	Number of Shares: Shared Power to Dispose
Harwood Capital	796,546		796,546	0	796,546
NASCIT	745,402		745,402	0	745,402
Christopher H. B. Mills	796,546		796,546	0	796,546

(9) Includes aggregate holdings under a joint filing on Schedule 13G dated and filed with the SEC on February 9, 2018 by Berggruen Holdings Ltd. ("BHL"), a BVI corporation and Nicholas Berggruen Charitable Trust ("NBCT"), a BVI trust. The following information is based solely on such filing. All of the shares of BHL are owned by the NBCT. The trustee of NBCT is Maitland Trustees Limited, a BVI

corporation acting as an institutional trustee in the ordinary course of business without the purpose or effect of changing or influencing control of the Company. Nicolas Berggruen, a United States citizen, is one of three directors of BHL, and as such, does not have beneficial ownership of any Common Shares beneficially owned by BHL. The principal business address of NBCT is: Midocean Chambers P.O. Box 805 Road Town, Tortola British Virgin Islands. BHL and NBCT report shared voting and dispositive power with respect to all of the reported shares listed above.

(10) Includes holdings reported on Schedule 13G dated March 15, 2016 by Wittenberg Investment Management, Inc. ("WIM") and Joel B. Wittenberg ("Wittenberg") and filed with the SEC on February 10, 2017. The following information is based solely on such filing. WIM is a California corporation, with its principal office located at 650 Concord Street, Suite 203, Carlisle, Massachusetts 01741. Wittenberg is a U.S. citizen whose principal business address is 650 Concord Street, Suite 203, Carlisle, Massachusetts 01741. Wittenberg is deemed the beneficial owner of the 716,549 shares beneficially owned by WIM. WIM and Wittenberg report shared voting and dispositive power with respect to all of the reported shares.

(11) Includes 480,000 shares that may be acquired under options exercisable within 60 days of September 23, 2019, 203,584 shares owned by CareVest, and 574,602 shares owned by Beilihis.

PROPOSAL 1 TO BE VOTED ON BY SHAREHOLDERS

Proposal 1—Election of Directors

The Company's board of directors is comprised of six (6) members. One class of directors is normally elected at each annual meeting of shareholders for a term of two (2) years. At the 2019 annual meeting, shareholders will elect three (3) members to the board of directors who will hold office until the annual meeting of shareholders in 2021. The board has nominated Robert M. Thornton, Jr., Dr. Steven J. Baileys and Gene E. Burleson for re-election as directors for terms of office of two (2) years, and until their successors are elected and qualified.

It is the intention of the proxy agents named in the proxy, unless otherwise directed, to vote such proxies for the election of Robert M. Thornton, Jr., Dr. Steven J. Baileys, and Gene E. Burleson.

Should any of such nominees be unable to accept the office of director, an eventuality which is not anticipated, proxies may be voted with discretionary authority for a substitute nominee or nominees designated by the board.

The board of directors unanimously recommends a vote "FOR" the election of Robert M. Thornton, Jr., Dr. Steven J. Baileys, and Gene E. Burleson

INFORMATION CONCERNING THE BOARD OF DIRECTORS

Identification of Directors

The following table sets forth certain information about the nominees for election and the directors whose terms of office will continue after the meeting.

Current Nominees:	Name and Offices Presently Held with Company	Director Since
Robert M. Thornton, Jr	Director, Chairman, President and Chief Executive Officer	1996
Dr. Steven J. Baileys	Director	2000
Gene E. Burleson	Director	2003

Directors Whose Term of Office Expires in 2020:	Name and Offices Presently Held with Company	Director Since
C. Michael Ford	Director	1999
Christopher H. B. Mills	Director	2007
Howard E. Turner	Director	1999

Certain information concerning each person listed in the above table, including his or her principal occupation for at least the last five (5) years, is set forth below.

Robert M. Thornton, **Jr**., 70, has been Chairman and Chief Executive Officer of the Company since September 10, 1998, President since July 16, 1996 and was Chief Financial Officer from July 18, 1997 through August 31, 2002. From October 1994 to the present, Mr. Thornton also is a private investor in, and, since March 1995, has been Chairman and Chief Executive Officer of, CareVest Capital, LLC, a private investment and management services firm. Mr. Thornton was a director of and held various executive offices with, Hallmark Healthcare Corporation from October 1989 until Hallmark's merger with Community Health Systems, Inc. in October 1994. Mr. Thornton was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

Dr. Steven J. Baileys, 65, is a private investor and was Chairman of the Board of Directors of SafeGuard Health Enterprises, Inc., a public dental care benefits company, from July 1995 to June 2004. Dr. Baileys was Chief Executive Officer of SafeGuard from April 1995 to February 2000, its President from December 1981 until May 1997, and its Chief Operating Officer from December 1981 until April 1995. Dr. Baileys is licensed to practice dentistry in the State of California. Dr. Baileys was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

Gene E. Burleson, 78, is a private investor and was Chairman of PET DRx Corporation from June 2005 to July 1, 2010 and its Chief Executive Officer from October 2008 until its acquisition by VCA Antech in July 2010. Mr. Burleson was a director of HealthMont Inc. from September 2000 until its acquisition by SunLink in October 2003. Mr. Burleson served as Chairman of Mariner Post-Acute Network, Inc. from January 2000 to June 2002. Mr. Burleson was Chairman of the Board of GranCare Inc. from October 1990 to November 1997 and President and Chief Executive Officer of GranCare Inc. from December 1989 to February 1997. From June 1986 to March 1989, Mr. Burleson served as President, Chief Operating Officer, and Director of American Medical International Inc. ("AMI"). Mr. Burleson served as Managing Director of AMI's international operations from May 1981 to June 1986. Mr. Burleson was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

C. Michael Ford, 80, has been President of Ocmulgee Land Trust, Inc. since July 2011. Mr. Ford was the Chief Executive Officer of Newtown Macon, Inc. from December 2003 to March 2014. He was Chairman of the Board of In Home Health, Inc. from February 2000 to December 2000. Mr. Ford also served as Vice President of Development of Columbia/HCA Healthcare Corporation from September 1994 to September 1997, and was Vice President of Marketing of Meditrust Corp. from October 1993 to September 1994. Mr. Ford was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

Christopher H. B. Mills, 66, is a Director and the Chief Investment Officer of Harwood Capital Management and has served in such capacity since October 30, 2011. Mr. Mills also serves as the Managing Director/Investment Manager of North Atlantic Smaller Companies Investment Trust plc and Trident North Atlantic, positions he has held since 1998. From January 1993 until October 2011, Mr. Mills was a Director and the Chief Investment Officer of J. O. Hambro. From 1984 to 1993, Mr. Mills was a Director of MIM Management Limited. Mr. Mills was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

Howard E. Turner, 77, has been a partner in the law firm of Smith, Gambrell & Russell, LLP, since 1971. Mr. Turner has served in the past as a director of Avlease, Ltd., a lessor of large commercial aircraft, and as an officer and director of Historic Motorsports Holdings, Ltd. Mr. Turner provides legal services to the Company through the law firm, Smith, Gambrell & Russell, LLP, as requested by the Company. Mr. Turner was deemed qualified to serve on the board for the reasons set forth below under Director Qualifications, including his business experience set forth herein.

Nomination Procedures and Shareholder Nominations

The board does not have a nominating committee but has adopted a nominating resolution which provides that the board believes it to be in the best interest of the Company and the best interest of the Company's shareholders to authorize the entire board to identify and nominate, by majority vote of the entire board then in office, directors to serve on the Company's board so long as, pursuant to rules of the NYSE American exchange director nominees so selected are approved by a majority of the independent directors and, when vacancies occur on the board which are to be filled, that the board will actively seek individuals qualified to become board members based on business experience, professional expertise, industry experience, and diversity. Shareholders who wish to submit nominees for election at an annual or special meeting of shareholders should follow the procedure generally described in *Requirements, Including Deadlines, For Submission Of Proxy Proposals, Nomination Of Directors And Other Business Of Shareholders* on page 29 of this Proxy Statement and more particularly, in the Company's Code of Regulations. The board applies the same standards in considering candidates submitted by shareholders as it does in evaluating candidates submitted by members of the board. The board does not have a separate policy with regard to the consideration of candidates recommended by shareholders other than the process provided in the nominating resolution.

Director Qualifications

The board concluded that each continuing director and each director nominated for re-election was qualified to serve as a director of SunLink and recommended the nominees for election or re-election at the current year's annual meeting. No single factor was more important than any other factor in the evaluation of any director or selection of any director nominee and the board made its determination on the basis of its own experience and subjective evaluation of each individual, with reference to various objective criteria required by law or other regulatory requirements, including but not limited to independence requirements and stock exchange regulations, as well as the subjective criteria that each director has deemed desirable in evaluating nominations.

Each director nominated for re-election and each continuing director was deemed by the board to have: met applicable legal and regulatory definitions of independence excluding from such independence determination only Mr. Thornton, the Company's sole management director; met the criteria set forth in the Company's corporate governance guidelines; a reputation for and to have displayed, personal integrity and judgment; achieved professional prominence in their business careers; manifested concern for the interests of the Company's shareholders; sufficient time available for service on the SunLink board taking into account such person's other professional and personal commitments; demonstrated a commitment to the Company based on their current and historical service to the Company as a director and/or as an executive officer of the Company; a general understanding of marketing, finance, and other disciplines relevant to the success of a publicly traded company in today's business environment; and knowledge with respect to the current state of the Company based on their current and historical service to the Company as a director and/or as an executive officer of the Company.

Board members with long board service to the Company (Baileys, Burleson, Ford, Mills, Thornton, and Turner), prior experience in the healthcare services industry (Burleson, Ford, and Thornton), current and prior experience providing legal services to clients in the healthcare industry (Turner), prior experience in businesses ancillary to the healthcare services industry (Burleson, Ford, and Thornton), or a combination thereof, as set forth in greater detail in their individual biographies, were deemed to have applicable industry or related industry experience relevant to the Company. Board members identified in greater detail in their individual biographies as having served as officers of other healthcare services providers (Burleson, Ford, and Thornton) or a current officer of the Company (Thornton) were deemed to have had operational experience relevant to the Company. Directors identified elsewhere in this Proxy Statement in greater detail as serving on specific committees of the board were deemed to have experience in matters relevant to their current committee assignments including executive compensation (Baileys and Burleson) and financial expertise (Ford and Mills). Each director identified in greater detail in their biographies as a nominee or continuing director of SunLink or as having served as an officer, director or both of one or more other public companies (Baileys, Burleson, Thornton, and Mills) was deemed to have experience relevant to SunLink as a public company and to the discharge of the duties of such persons as directors of a public company. Each non-management director with prior CEO experience (Baileys, Burleson, and Ford) and corporate legal experience (Turner) was deemed to have experience relevant to their oversight of the Company's management in general and its CEO in particular. Each director identified in their biography as having applicable healthcare services industry experience (Baileys, Burleson, Ford, and Thornton), or healthcare legal experience (Turner) was deemed to have applicable industry regulatory experience. Each director identified as having experience in industries which are or have been highly competitive (all) or highly regulated, especially the financial services industries (Mills), were deemed to have experience relevant to the Company in its own business which is both highly competitive as well as highly regulated. Each director was deemed of sufficient age and maturity to have accumulated the life experiences, viewpoints, and expertise necessary to perform the duties of a public company director, as well as being able to vigorously perform his or her duties as a director of the Company.

The board conceptualizes diversity expansively to include differences of viewpoint, professional experience, and skill sets, especially in matters of healthcare service operations and regulations, financing, marketing, and human resources, as well as a subjective determination of individual qualities, attributes, and differences. The board has taken into account the benefits of, but has not ascribed any specific weight to, or adopted any formal policy with respect to, matters of geographic and cultural background, race, and gender. The board evaluates each individual in the context of the board as a whole, with the objective of recommending a group that can best facilitate the success of SunLink's business and represent shareholder interests through the exercise of sound judgment using its diversity of experience. The board evaluates each incumbent director to determine whether such director should be nominated to stand for re-election based on the types of criteria outlined above as well as the director's contributions to the board during their current term. Because the assessment of the diversity of the board as well as the effectiveness of the current factors in achieving diversity from a variety of perspectives is based on the individual subjective evaluation of each of the board members, the Company does not engage in any formal benchmarking procedure.

Board Meetings

The board of directors held seven (7) meetings during fiscal 2019. The board had four (4) standing committees during fiscal 2019: an executive committee, an audit committee, a compensation committee and a strategic planning committee. Each standing committee had the right to retain, in the fiscal year ended June 30, 2019, its own legal and other advisors. During the fiscal year ended June 30, 2019, all directors, except Mr. Mills, attended 75% or more of the meetings of the full board. During the fiscal year ended June 30, 2019, all directors attended 75% or more of the meetings of the individual committees of the board upon which they served.

Committees of the Board—Overview

Membership On Board Committees

This table lists the four (4) board committees in existence during our last fiscal year and the directors who currently serve on them and the number of committee meetings held in the fiscal year ended June 30, 2019.

Name	Audit	Compensation	Executive	Strategic
Dr. Baileys		●		C
Mr. Burleson	●	C		●
Mr. Ford	C			●
Mr. Mills				
Mr. Thornton			C	
Mr. Turner			●	
2019 Meetings	4	2	1(1)	0

C = Chairperson

• = Member

(1) In addition, the Executive Committee took one action in writing.

Audit Committee

The audit committee's primary function is to assist the board in fulfilling its oversight responsibilities by:

- selecting the Company's independent registered public accounting firm and evaluating the independence, performance, and continued retention of such accounting firm;

- reviewing the Company's auditing, accounting, and financial reporting processes generally;
- reviewing the Company's systems of internal controls regarding finance, accounting, legal, and compliance that management and the board have established;
- reviewing the integrity of the financial statements and other financial information provided by the Company to the Company's shareholders, the general public, and the SEC, including:
  - reviewing and discussing with management and the independent registered public accounting firm the financial statements to be included in the Company's annual report on Form 10-K for filing with the SEC;
  - discussing with the independent registered public accounting firm the conduct of the audit, the adequacy and effectiveness of the Company's accounting and financial controls, and the written disclosures required by Independence Standards Board Standard No. 1 regarding such firm's independence;
  - meeting separately with the independent registered public accounting firm and with the Company's internal auditor, as well as the Company's other management, to discuss the results of their audits; and
  - reviewing and discussing with management and the independent registered public accounting firm the Company's interim financial statements as included in the Company's quarterly reports;
- reviewing the potential engagement of the Company's independent registered public accounting firm for non-audit services prior to any such engagement and approving any such engagement;
- reassessing annually the adequacy of the audit committee charter and recommending any proposed changes to the board for approval;
- reporting to the Company's board the conclusions with respect to the matters that the audit committee has considered; and
- examining such other areas or activities consistent with the audit committee charter, the Company's Code of Regulations and governing law as the audit committee or board deem appropriate.

The audit committee has adopted a procedure to receive allegations on any fraudulent accounting issues through a toll-free telephone number and email as set out in the Company's Code of Conduct.

Each member of the audit committee is independent as defined in Section 803(A) of the NYSE American exchange Company Guide and Rule 10A-3 of the Exchange Act. The board has also determined that Mr. Ford meets the requirements for being an "audit committee financial expert" pursuant to Section 407 of the Sarbanes-Oxley Act of 2002. Our audit committee charter is available on our website at *www.sunlinkhealth.com*.

Compensation Committee

Composition; Independence; Insider Participation

Our compensation committee is composed entirely of independent members of the board. All three (3) members of the compensation committee are independent, as defined in Section 803(A) of the NYSE American exchange Company Guide and each of them qualifies as an "outside director" (as such term is defined in Section 162(m) of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations thereunder). Our compensation committee charter is available on our website at *www.sunlinkhealth.com*. No member of the committee is a current or former employee or officer of the Company or any of its affiliates.

Compensation Review Process; Management Participation in Compensation Determinations

The compensation of our executive officers is determined by the compensation committee on an annual basis subject to minimum compensation thresholds pursuant to employment agreements and letters previously approved by the committee. Our compensation committee considers all elements of compensation in making its determinations. With respect to those executive officers who do not serve on our board, the committee also considers the recommendations of our chairman of the board and chief executive officer. The compensation committee meets at various times during the year, and it also considers and takes action by written consent. The compensation committee chairperson reports on committee actions and recommendations at board meetings.

Responsibilities

The compensation committee has the power and authority of the board to perform and performs the following duties and responsibilities:

- Develops guidelines and, on an annual basis, reviews the compensation and performance of the Company's senior executive officers; reviews and approves corporate goals relevant to the compensation of the chief executive officer; evaluates the chief executive officer's performance in light of these goals and objectives; sets the chief executive officer's compensation based on such evaluation; evaluates the performance of the Company's other senior executive officers and approves their annual compensation;
- Makes recommendations to the board with respect to incentive compensation plans and equity-based plans, and administers such plans by establishing criteria for granting of awards to the Company's officers and other employees and reviews and approves the granting of awards in accordance with such criteria;
- Reviews and approves plans for managerial succession of the Company;
- Reviews director compensation levels and practices, and recommends to the board, from time to time, changes in such compensation levels and practices (including retainers, meetings fees, committee fees, stock options and other similar items as appropriate);
- Annually reviews and assesses the adequacy of the Compensation Committee Charter and recommends any proposed changes to the board for approval; and
- Performs such other activities consistent with the Compensation Committee Charter, the Company's Code of Regulations and governing law as the compensation committee or the board deems appropriate.

Executive Committee

The executive committee is empowered to exercise all of the authority of the board except as to matters not delegable to a committee under the General Corporation Law of Ohio.

Strategic Planning Committee

Pursuant to guidelines established by the board, the Strategic Planning Committee is empowered to review offers to purchase more than 20% of the Company's outstanding common shares and provide analysis to the board in connection with the evaluation of any such offers by the full board.

COMPENSATION OF DIRECTORS FOR FISCAL YEAR 2019

Management Directors

We do not pay directors who are also our employees any additional compensation for serving as a director, other than customary reimbursement of expenses.

Non-Management Directors

The Company believes that the compensation of non-management directors should be at a level which is sufficient to attract talented and diverse individuals to serve on the Company's board while, at the same time, avoiding compensation levels where the level of compensation might present the appearance of a potential lack of director independence. However, in recent years, the board has limited director compensation in light of the Company's recent financial performance to levels below those which the board would otherwise deem appropriate.

The following chart discloses the compensation of each non-management director for the fiscal year ended June 30, 2019:

Name[(1)]	Fees Earned or Paid in Cash ($)	Totals ($)[(2)]
Dr. Steven J. Baileys	39,500	39,500
Gene E. Burleson	43,000	43,000
C. Michael Ford	43,000	43,000
Christopher H. B. Mills	39,500	39,500
Howard E. Turner(3)	39,500	39,500
Karen B. Brenner(4)	15,000	15,000

(1) **Cash Compensation.** Effective December 1, 2018, non-management directors received a base fee for director compensation of $42,000 per year, payable on a monthly basis in equal installments. In addition, each non-management committee chair of the Audit Committee and Compensation Committee received an annual fee of $6,000.00 per year, payable on a monthly basis in equal installments.

(2) None of the directors received any equity based awards, non-equity incentive plan compensation, any pension benefits, any non-qualified deferred compensation or any other compensation for the fiscal year ended June 30, 2019.

(3) **Other Arrangements.** Mr. Turner is a partner of the law firm of Smith, Gambrell & Russell, LLP. Such law firm provided legal services to the Company in the fiscal year ended June 30, 2019 at customary rates and continues to provide such services to the Company in the fiscal year ending June 30, 2020.

(4) Ms. Brenner did not stand for re-election at the annual meeting in 2018.

The following chart discloses certain information with respect to option awards held by each non-management director as of the fiscal year ended June 30, 2019:

Aggregate Option Awards Outstanding At Fiscal Year End[1]

Name	Number of Securities Underlying Unexercised Options (#) Exercisable	Option Exercise Price ($)	Option Expiration Date
Dr. Steven J. Baileys	10,000	1.67	11/10/2021
	20,000	1.22	09/05/2022
	3,000	0.71	09/16/2023
	5,000	1.79	09/10/2025
	12,000	1.21	09/12/2026
Gene E. Burleson	10,000	1.67	11/10/2021
	20,000	1.22	09/05/2022
	3,000	0.71	09/16/2023
	5,000	1.79	09/10/2025
	12,000	1.21	09/12/2026
C. Michael Ford	10,000	1.67	11/10/2021
	20,000	1.22	09/05/2022
	3,000	0.71	09/16/2023
	5,000	1.79	09/10/2025
	12,000	1.21	09/12/2026
Christopher H. B. Mills	10,000	1.67	11/10/2021
	20,000	1.22	09/05/2022
	3,000	0.71	09/16/2023
	5,000	1.79	09/10/2025
	12,000	1.21	09/12/2026
Howard E. Turner	10,000	1.67	11/10/2021
	20,000	1.22	09/05/2022
	3,000	0.71	09/16/2023
	5,000	1.79	09/10/2025
	12,000	1.21	09/12/2026

(1) There were no outstanding stock awards or non-equity incentive plan awards for directors during the fiscal year or at fiscal year end. Subsequent to year end, the board granted options to each non-management director to purchase 10,000 shares at an exercise price of $1.38 per share and with a grant date fair value of $1.38 per share. All of such options vested as of September 9, 2019, which was the date of grant. If we grant other stock options, stock awards or non-equity plan incentive awards to our directors in the future, we will report the named director holding unvested securities, the grant date fair value of equity awards computed in accordance with FASB ASC Topic 718, the vesting date for such securities, and the number of securities vesting on the applicable date.

EXECUTIVE OFFICERS

Our executive officers, as of September 23, 2019, their positions with the Company or our subsidiaries, and the ages of such executive officers are as follows:

Name	Office	Age
Robert M. Thornton, Jr.	Director, Chairman of the Board of Directors, President and Chief Executive Officer	70
Mark J. Stockslager	Chief Financial Officer and Principal Accounting Officer	60
Byron D. Finn	President, SunLink ScriptsRx, LLC	69

Current Executive Officers

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

Biographical information for our non-director executive officers is set forth below:

Mark J. Stockslager, 60, has been SunLink's Chief Financial Officer since July 1, 2007. He was interim Chief Financial Officer from November 6, 2006 until June 30, 2007. He has been the Principal Accounting Officer since March 11, 1998 and was Corporate Controller from November 6, 1996 to June 4, 2007. He has been associated continuously with our accounting and finance operations since June 1988 and has held various positions, including Manager of U.S. Accounting, from June 1993 until November 1996. From June 1982 through May 1988, Mr. Stockslager was employed by Price Waterhouse & Co.

Byron D. Finn, 69, has been President of SunLink ScriptsRx, LLC since October 1, 2010. Previously, Mr. Finn was President of Byron D. Finn, CPA, PC, which provided accounting, financial consulting, and litigation support services for clients, including numerous healthcare clients. His experience also includes various positions with The Coca-Cola Company, where he served in a number of financial-related positions and in connection with special projects, and he was previously employed by Ernst & Young. Mr. Finn is a licensed CPA and received his Bachelor of Business Administration and Master of Accountancy degrees from the University of Georgia.

EXECUTIVE COMPENSATION

The following sections of this Proxy Statement set forth compensation information relating to the Company's principal executive officer (Mr. Thornton, who is our Chief Executive Officer), the Company's principal financial officer (Mr. Stockslager, who is our Chief Financial Officer), and our sole other named executive officer (Mr. Finn, who is the President of SunLink ScriptsRx).

Summary Compensation Table

The following table shows the compensation awarded or paid by SunLink for services rendered for the fiscal years ended June 30, 2019 and 2018 to the named executive officers.

Name and Principal Position	Year	Salary ($)	Bonus ($)[1]	Change in Pension Value and Nonqualified Defined Compensation Earnings ($)[2]	All Other Compensation ($)[3]	Total ($)[4]
Robert M. Thornton, Jr.	2019	366,000	67,721	2,193	4,397	440,311
Chairman, President and Chief Executive Officer	2018	366,000	51,000	2,507	8,372	427,879
Mark J. Stockslager	2019	190,000	22,407	4,626	3,516	220,549
Chief Financial Officer and Principal Accounting Officer	2018	190,000	25,000	5,642	6,461	227,103
Byron D. Finn	2019	200,000	48,000	N/A	170[5]	248,170
President, SunLink ScriptsRx, LLC	2018	200,000	68,700	N/A	170[5]	268,870

(1) Represents discretionary bonus awarded by the Company's compensation committee in light of its judgment regarding management's performance with respect to management of the Company's finances, results of operations, dispositions of nonperforming assets and application of proceeds thereof, and other factors deemed relevant in the subjective discretion of the compensation committee. With respect to fiscal 2019 and 2018, the compensation committee retained full authority to determine, among other things, the identity of participants to whom any bonuses would be payable (if at all), whether facts and circumstances merited the award of any bonuses, and the amount of bonuses awarded, if any.

(2) The KRUG International Corp. Retirement Plan (the "Plan"), the Company's sole defined benefit plan, was frozen and closed to new participants effective February 28, 1997. Mr. Thornton and Mr. Stockslager are the only named executive officers of the Company who are participants in the Plan and were credited with two and eight years of service, respectively, when the Plan was frozen. The amount reported in the table above represents the aggregate change in the actuarial present value of the named executive officer's accumulated benefit under the Plan from the measurement date used for financial statement reporting purposes for the prior completed fiscal year to the measurement date used for financial statement reporting purposes for the covered fiscal year. Because the Plan was frozen on February 28, 1997, compensation after such date is not used in determining a participant's accrued benefit. The present value of the accumulated benefits for Mr. Thornton and Mr. Stockslager is $35,848 and $78,124, respectively. Mr. Thornton's benefit is increasing as he has deferred receiving payments despite being eligible to do so at age 65. The present value of accumulated benefits changes as it is determined as a net present value using an interest rate which changes quarterly as determined by the United States Department of Labor. At June 30, 2019, the estimated future monthly benefits to be received by Messrs. Thornton and Stockslager were $251.19 and $601.24, respectively. Neither Mr. Thornton nor Mr. Stockslager received any payments under the Plan in the last fiscal year.

(3) All other compensation consisted solely of life, medical, and dental insurance premiums paid above those premiums which are generally paid for all employees and 401k contributions made by the Company.

(4) None of the named executive officers received any stock awards or non-equity incentive compensation (other than annual bonuses) in fiscal 2019 or fiscal 2018.

(5) Consists solely of life insurance premiums.

Outstanding Equity Awards at Fiscal Year-End

The following table provides information with respect to common shares that may be issued upon the exercise of options and other awards outstanding under the Company's existing equity compensation plans as of June 30, 2019 to the Company's named executive officers.

	Option Awards[1]			
Name[2]	Number of Securities Underlying Unexercised Options (#)[1] Exercisable	Number of Securities Underlying Unexercised Options (#) Unexercisable	Option Exercise Price ($)	Option Expiration Date
Robert M. Thornton, Jr.	20,000	—	1.22	09/05/2022
	20,000	—	1.22	09/05/2022
	20,000	—	1.22	09/05/2022
	20,000	—	1.49	09/12/2024
	20,000	—	1.49	09/12/2024
	20,000	—	1.49	09/12/2024
Mark J. Stockslager	10,000	—	1.22	09/05/2022
	10,000	—	1.22	09/05/2022
	10,000	—	1.22	09/05/2022
	10,000	—	1.49	09/12/2024
	10,000	—	1.49	09/12/2024
	10,000	—	1.49	09/12/2024

(1) Each option entitles the holder thereof to purchase one common share. Excludes options surrendered subsequent to year-end. Subsequent to June 30, 2019, Mr. Thornton and Mr. Stockslager surrendered out of the money options to the Company for no consideration. Mr. Thornton surrendered options for 130,000 shares, of which 30,000 options had an exercise price of $1.79 per share with an expiration date of September 10, 2025 and 100,000 options had an exercise price of $2.09 per share with an expiration date of September 12, 2021. Mr. Stockslager surrendered options for 35,000 shares, of which 20,000 options had an exercise price of $2.09 per share with an expiration date of September 12, 2021 and 15,000 options had an exercise price of $1.79 per share with an expiration date of September 10, 2025. There are no outstanding share awards for any named executive officers.

Securities Authorized for Issuance under Equity Compensation Plans

The following provides tabular disclosure of the number of securities at June 30, 2019 to be issued upon the exercise of outstanding options, the weighted average exercise price of outstanding options and the number of securities remaining available for future issuance under equity compensation plans, reported by two categories - plans that have been approved by shareholders and plans that have not been so approved:

Plan Category	(a) Number of securities to be issued upon exercise of outstanding options	(b) Weighted average exercise price of outstanding options	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
Equity compensation plans approved by security holders:			
2005 Equity Incentive Plan	345,000	$1.71	0
2011 Director Stock Option Plan	250,000	1.28	50,000
Total	595,000	$1.53	50,000
Equity compensation plans not approved by security holders:			
None	0	0.00	0
Total	595,000	$1.53	50,000

Subsequent to year end, the board granted options to each non-management director to purchase 10,000 shares at an exercise price of $1.38 per share and with a grant date fair value of $1.38 per share. All of such options vested as of September 9, 2019, which was the date of grant.

Employment Contracts, Termination of Employment and Change-in-Control Arrangements

Employment Agreements

Robert M. Thornton, Jr. Mr. Thornton, Chairman, President and Chief Executive Officer, is currently employed by the Company under the terms of an employment agreement effective July 1, 2005, as amended to date, for a term ending June 30, 2020. Absent notice, the contract provides for automatic renewal at the end of its then current term for a period of eighteen months. Mr. Thornton's current employment agreement provides for a base salary at a rate of not less than $335,000 per annum plus any increases that may be granted at least annually by the Company. Mr. Thornton's base salary for fiscal 2019 was $366,000. Mr. Thornton is eligible to participate in the Company's employee equity compensation plans if equity is available thereunder and if the compensation committee decides to grant him additional equity compensation. Under his employment agreement, Mr. Thornton is also eligible to receive an annual bonus of up to seventy percent of his annual base salary if certain criteria established by the compensation committee (in consultation with him) are met. Mr. Thornton is eligible to participate in the Company's medical, dental, life, and disability programs.

Mr. Thornton's employment agreement also provides for severance payments in the event Mr. Thornton ceases to be employed by the Company. If Mr. Thornton is terminated due to death, disability or cause, he is entitled to the accrued compensation under his employment agreement, including a pro rata share of any annual bonus. If Mr. Thornton is terminated other than for death, disability or cause, he is entitled to receive severance payments equal to thirty months of his then current salary, a pro rata portion of any annual bonus for which goals have been proportionately met, and continuation of certain benefits for and during the thirty months following termination.

Mark J. Stockslager. Mr. Stockslager, Chief Financial Officer and Principal Accounting Officer, is currently employed by the Company under the terms of an employment letter effective January 1, 2001. Mr. Stockslager's current employment letter provides for a salary of at least $7,333 per month or $88,000 on an annualized basis, which will be reevaluated at least annually to determine if any adjustments should be made. Currently, Mr. Stockslager's salary is $15,833 per month or $190,000 on an annualized basis. Additionally, Mr. Stockslager is also eligible to receive an annual bonus of up to sixty percent of his annual base salary if criteria established by the compensation committee are met. Mr. Stockslager is eligible to participate in the Company's employee equity compensation plans if equity is available thereunder and if the compensation committee decides to grant him additional equity compensation. Mr. Stockslager is eligible to participate in the Company's medical, dental, life and disability programs. Except as described below with respect to payments in connection with a change in control, if Mr. Stockslager is terminated, other than for cause, as determined by the board in its sole discretion, he is entitled to severance pay by continuation of his base salary for nine months.

Byron D. Finn. Mr. Finn, President, SunLink ScriptsRx, LLC is currently employed by the Company under the terms of an employment letter effective September 30, 2010. Mr. Finn's current employment letter provides for a salary of $16,667 per month or $200,000 on an annualized basis, which will be reevaluated at least annually to determine if any adjustments should be made. Additionally, Mr. Finn is eligible to receive an annual bonus of up to sixty percent of his annual base salary if criteria established by the compensation committee are met. Mr. Finn is eligible to participate in the Company's employee equity compensation plans if equity is available thereunder and if the compensation committee decides to grant him equity compensation. Mr. Finn is eligible to participate in the Company's medical, dental, life and disability programs. If Mr. Finn is terminated, other than for cause, Mr. Finn will be entitled to receive severance pay by continuation of his base salary for six months.

Change in Control Arrangements

With regard to the employment agreements with Mr. Thornton, Mr. Stockslager, and Mr. Finn, a "change in control" will be deemed to have occurred in the event that any of the following events shall have occurred (with defined terms, not otherwise defined herein, having the meanings associated with them in the employment agreements):

- Any Person, or Persons acting together that would constitute a "group," together with any Affiliates or Related Persons thereof (other than any employee stock ownership plan), beneficially owns 40% or more of the total voting power of all classes of Voting Stock of the Company, except an acquisition by (i) an employee benefit plan maintained by the Company or another corporation controlled directly or indirectly by the Company; (ii) the Company or any Subsidiary; (iii) executive or any Person controlled by an executive, under common control with executive or acting in concert with executive; or (iv) any Person in connection with a non-control transaction;
- The individuals who, as of the date of the agreement, are members of the board (the "incumbent board") cease for any reason to constitute at least two-thirds of the board; *provided*, *however*, that if the election, or nomination for election by the Company's shareholders, of any new director was approved by a vote of at least two-thirds of the incumbent board, such new director shall, for purposes of change in control, be considered as a member of the incumbent board; *provided*, *further*, *however*, that no individual shall be considered a member of the incumbent board if such individual initially assumed office as a result of either an actual or threatened "Election Contest" (as described in Rule 14a-11 promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a Person other than the board (a "proxy contest") including by reason of any agreement intended to avoid or settle any Election Contest or proxy contest;
- Approval by shareholders of SunLink of a merger, consolidation or reorganization involving the Company, unless
  - the shareholders of the Company, immediately before such merger, consolidation or reorganization, own, directly or indirectly, immediately following such merger, consolidation or reorganization, at least two-thirds of the combined voting power of the outstanding voting securities of the corporation resulting from such merger or consolidation or reorganization (the

"surviving corporation") in substantially the same proportion as their ownership of the voting securities immediately before such merger, consolidation or reorganization, and

- the individuals who were members of the incumbent board immediately prior to the execution of the agreement providing for such merger, consolidation or reorganization constitute at least two-thirds of the members of the board of directors of the surviving corporation; or

- If the executive's employment is terminated prior to a change in control and the executive reasonably demonstrates that such termination (A) was at the request of a third party who has indicated an intention or taken steps reasonably calculated to effect a change-in-control and who effectuates a change in control (a "third party") or (B) otherwise occurred in connection with, or in anticipation of, a change-in-control which actually occurs, then for all purposes, the date of a change in control with respect to the executive shall mean the date immediately prior to the date of such termination of the executive's employment.

Upon a change in control, if Mr. Thornton's employment is thereafter terminated for any reason other than cause or if he terminates his employment within one year of the change in control, he is entitled to (a) thirty months of base pay, to be paid in accordance with the Company's payroll practices; (b) accrued compensation, including a pro rata portion of any annual bonus for which goals have been proportionately met; (c) health and certain ancillary benefits for twenty four months following termination; and (d) full vesting of any then unvested stock options.

Upon a change in control, if Mr. Stockslager's employment is thereafter terminated for any reason other than cause or if he terminates his employment within one year of the change-in-control, he is entitled to twelve months of base pay, to be paid in accordance with the Company's payroll practices.

Upon a change in control, if Mr. Finn's employment is terminated within 90 days thereafter for any reason other than death, disability or cause, he is entitled to six months of base pay, to be paid in accordance with the Company's payroll practices.

The following table sets forth certain potential benefits which would have been realized in connection with a *change in control and termination of employment without cause or at the election of the executive* for the Company's principal executive officer, principal financial officer, and the Company's sole other named executive officer for fiscal year 2019 assuming the change in control and termination occurred as of the last day of the most recently completed fiscal year.

Name and Principal Position	**Continued Base Salary[(1)] $**	**Lump Sum Salary Bonus and Incentive Compensation Payment[(2)] $**	**Value of Health and Insurance Benefits[(3)] $**	**Value of Accelerated Equity Awards[(4)] $**	**Total Termination Benefits $**
Robert M. Thornton, Jr. Chairman, President and Chief Executive Officer	915,000	0	22,279	0	937,279
Mark J. Stockslager Chief Financial Officer and Principal Accounting Officer	190,000	N/A	N/A	N/A	190,000
Byron D. Finn President, SunLink ScriptsRx, LLC	100,000	N/A	N/A	N/A	100,000

(1) The thirty-month continued base salary benefit is to be paid in accordance with the Company's regularly scheduled pay periods over the applicable benefits period.

(2) In the event of a change in control to be calculated as a pro rata portion of any annual bonus for which goals have been proportionately met prior to termination and without regard to any requirement to be employed on payment date. Such payment shall be made after an audit of annual results in accordance with the applicable plan. Because bonus amounts payable to Mr. Thornton for 2019 were, and for 2020 are, based on the judgment of the compensation committee in its sole discretion, the reported pro forma change of control bonus amount is zero.

(3) Calculated based on the aggregate health insurance premiums payable over twenty four months and assuming the exercise of all rights of the covered individual under COBRA, without adjustment for increases in cost, plus premiums for supplemental life insurance, without adjustment for increases in cost, multiplied by the assumed actuarial lives of the persons provided supplemental life insurance benefits or the maximum supplemental life insurance benefit period if shorter.

(4) Calculated based on the sum of the number of accelerated option awards, multiplied by the positive difference, if any, between the exercise price of such option and the market price of the Company's common shares at June 30, 2019.

PROPOSAL 2 TO BE VOTED ON BY SHAREHOLDERS

Proposal 2—Ratification of Independent Registered Public Accounting Firm

Cherry Bekaert LLP, an independent registered public accounting firm (“Cherry Bekaert”), was engaged to perform the Company’s annual audit for the fiscal year ended June 30, 2019. We anticipate that representatives of Cherry Bekaert will be present at the 2019 annual meeting of shareholders to respond to appropriate questions and to make a statement if such representatives so desire.

The audit committee has appointed Cherry Bekaert to serve as the Company’s independent registered public accounting firm for the fiscal year beginning July 1, 2019. We are asking our shareholders to ratify the selection of Cherry Bekaert. Although ratification is not required by our Code of Regulations or otherwise, the board is submitting the selection of Cherry Bekaert to our shareholders for ratification as a matter of good corporate practice. If the selection is not ratified, the audit committee will consider whether it is appropriate to select another independent registered public accounting firm. Even if the selection is ratified, the audit committee, in its discretion, may select a different independent registered public accounting firm at any time during the year and may periodically request proposals from other independent registered public accounting firms and as a result of such process may select Cherry Bekaert or another independent registered public accounting firm if the audit committee determines that such a change or action would be in the best interests of the Company and our shareholders.

The board of directors unanimously recommends a vote “FOR” the ratification of the appointment of Cherry Bekaert LLP as our independent registered public accounting firm.

PROPOSAL 3 TO BE VOTED ON BY SHAREHOLDERS

Proposal 3—Ratification of Extension of Rights Plan Final Expiration Date to September 29, 2024

Previously, on September 29, 2016, the Company entered into the Tax Benefits Preservation Rights Plan (the “Rights Plan”) with American Stock Transfer & Trust, LLC, as Rights Agent.

Pursuant to the terms of the Rights Plan, the rights would have expire “at or prior to the earliest of (i) 5:00 P.M., New York, New York time, on September 29, 2019 or such later date as may be established by the Board prior to the expiration of the Rights as long as the extension is submitted to the shareholders of the Company for ratification at the next succeeding annual meeting of the shareholders of the Company (such date, as it may be extended by the Board, the “Final Expiration Date”), (ii) the time at which the Rights are redeemed as provided in Section 23 hereof, (iii) the time at which the Rights may be exchanged as provided in Section 24 hereof, (iv) the close of business on the effective date of the repeal of Section 382 of the Code if the Board determines that this Plan is no longer necessary or desirable for the preservation of Tax Benefits, or (v) the close of business on the first day of a taxable year of the Company to which the Board of Directors of the Company determines that no material Tax Benefits may be carried forward sufficient to justify continued restrictions on transfer (the earliest of (i) – (v) being herein referred to as the “Expiration Date”).

The Board has vote to extend the Final Expiration Date to September 29, 2024 and to amend the Rights Plan to substitute “September 29, 2024” for “September 29, 2019” in Section 7(a)(i) thereof. We are asking our shareholders to ratify the extension of the Final Expiration Date to September 29, 2024 and the amendment of the Rights Plan to substitute “September 29, 2024” for “September 29, 2019” in Section 7(a)(i) thereof. Although actual ratification of the extension and related amendment is not required by the Plan, our Code of Regulations or otherwise, the Board is submitting the extension of the Final Expiration Date and the related amendment of the Plan to our shareholders for ratification in accordance with the terms of the Plan. If the extension and related amendment is not ratified, the Board will consider whether it is appropriate to select another Final Expiration Date. Even if the extension and amendment is ratified, the Board, in its discretion, may select a different Final Expiration Date at any time prior to September 29, 2024 if the Board determines that such a change or action would be in the best interests of the Company and our shareholders.

The board of directors unanimously recommends a vote "FOR" the ratification of the extension of the Final Expiration Date and amendment of the Rights Plan in connection therewith.

CERTAIN ACCOUNTING AND AUDITING MATTERS

Report of the Audit Committee

The authority, duties, and responsibilities of the audit committee are set forth in detail in the written audit committee charter, which was adopted by the board and which complies with the applicable rules of the NYSE American exchange. The audit committee has three members, each of whom is independent under the applicable rules of the NYSE American exchange. In accordance with section 407 of the Sarbanes-Oxley Act of 2002, Mr. Ford has been identified as an "Audit Committee Financial Expert."

The audit committee reviews and assesses the adequacy of its charter on an annual basis. A copy of the Audit Committee Charter is available on the Company's website at *www.sunlinkhealth.com*.

The audit committee is responsible for overseeing the Company's financial reporting process on behalf of the board. Management of the Company has the primary responsibility for the Company's financial reporting process, principles, and internal controls as well as preparation of its financial statements in accordance with generally accepted accounting principles. The Company's independent auditors are responsible for performing an audit of the Company's financial statements and expressing an opinion as to the conformity of such financial statements with generally accepted accounting principles in the United States.

The audit committee met four (4) times during fiscal year 2019. In addition, the members of the audit committee reviewed, and the chairperson of the audit committee discussed with management and the Company's independent auditors, the interim financial information contained in each quarterly earnings release prior to the release of such information to the public.

The audit committee has reviewed and discussed the Company's audited financial statements as of and for the year ended June 30, 2019 with management and representatives of Cherry Bekaert. The audit committee has discussed with representatives of Cherry Bekaert the matters required to be discussed under Standards of the Public Company Accounting Oversight Board ("PCAOB"), including those matters set forth in Auditing Standards No. 1301, *Communication with Audit Committees*. In addition, the audit committee received from Cherry Bekaert the written disclosures and the letter required by the PCAOB's applicable requirements and has discussed with representatives of Cherry Bekaert its independence from the Company and its management. The audit committee also considered whether Cherry Bekaert's provision of non-audit services to the Company is compatible with maintaining Cherry Bekaert's independence. The audit committee has concluded that the independent auditors are independent from the Company and its management.

The audit committee discussed with Cherry Bekaert the overall scope and plans for their services. In addition, the audit committee met with the Chief Executive Officer and Chief Financial Officer of the Company to discuss the processes that they have undertaken to evaluate the accuracy and fair presentation of the Company's financial statements and the effectiveness of the Company's system of disclosure controls and procedures.

In fulfilling its oversight responsibilities and as part of its review of the Company's 2019 Annual Report, the audit committee met with representatives of Cherry Bekaert, with and without management present, to discuss their evaluations of the Company's internal controls as well as the overall quality of its financial reporting.

The fees paid to Cherry Bekaert, as well as the policy on pre-approval of audit and non-audit services are set forth elsewhere in this Proxy Statement.

As a result of the reviews and discussions with management and Cherry Bekaert referred to above, the audit committee recommended to the board and the board has approved that the audited financial statements of the Company be included in the Annual Report on Form 10-K for the fiscal year ended June 30, 2019 for filing with the SEC.

This report has been submitted by the audit committee:

C. Michael Ford (Chairperson) Gene E. Burleson

The foregoing report shall not be deemed incorporated by reference by any general statement incorporating by reference this Proxy Statement into any filing under the Securities Act of 1933.

Policy on Pre-Approval of Services Provided By Independent Registered Public Accounting Firm

Pursuant to the requirements of the Sarbanes-Oxley Act of 2002, the terms of the engagement of the Company's independent registered public accountant with respect to all auditing services and non-audit services to be performed for the Company by the Company's independent registered public accountants is subject to the specific pre-approval of the audit committee (except where such services are determined to be de minimis under the Exchange Act). All audit and permitted non-audit services to be performed by Cherry Bekaert require pre-approval by the audit committee in accordance with pre-approved procedures established by the audit committee. The audit committee may delegate to one or more designated members of the audit committee the authority to grant such pre-approvals. The decisions of any member to whom such authority is delegated are presented to the full audit committee at the next scheduled meeting of the audit committee. The procedures require all proposed engagements of the Company's independent registered public accountants for services of any kind to be directed to the Company's Principal Accounting Officer and then submitted for approval to the audit committee prior to the beginning of any services.

In fiscal year 2019, 100% of the audit fees, audit-related fees, and tax fees billed by Cherry Bekaert were approved either by the audit committee or its designee. The fees billed by Cherry Bekaert that are shown in the following table for fiscal year 2019 and 2018 were also pre-approved by the audit committee or its designee. The audit committee has considered whether the provision of non-audit services by Cherry Bekaert is compatible with maintaining the independence of such independent registered public accounting firm and believes that the provision of such services is compatible.

Independent Registered Public Accounting Firm Fees

The following tables show the type of services and the aggregate fees billed to the Company for such services during the fiscal years ended June 30, 2019 and 2018 by Cherry Bekaert[1]. Descriptions of the service types follow the table.

Services Rendered by Cherry Bekaert LLP	Fiscal 2019	Fiscal 2018
Audit Fees	$200,000	$109,621
Audit-Related Fees	0	1,830
Tax Fees	0[1]	0[1]
All Other Fees	0	0
TOTAL	$200,000	$111,451

[1] In fiscal 2019 and 2018, the professional services for tax compliance were performed by another public accounting firm. Such fees were $65,138 and $62,114 in fiscal 2019 and 2018 respectively, and were approved by the audit committee or its designee.

Audit Fees

The aggregate fees billed by Cherry Bekaert for each of the last two fiscal years include fees for professional services rendered for the audit of the Company's annual financial statements, review of financial statements included in the Company's Quarterly Reports on Form 10-Q, and consents and assistance with and review of other documents filed with the SEC, and accounting and financial reporting consultations and other attest services and the issuance of consents.

Audit-Related Fees

The aggregate fees billed by Cherry Bekaert in each of the last two fiscal years include fees for assurance and related services that are reasonably related to the performance of the audit or review of the Company's financial statements. The nature of the services performed for these fees may include, among other things, employee benefit plan audits, internal control reviews, attest services not required by statute or regulation and consultations concerning financial accounting and reporting matters not classified as an audit.

Tax Fees

The aggregate fees billed by Cherry Bekaert in each of the last two fiscal years did not include fees for professional services rendered for tax compliance or assisting the Company with tax audits.

All Other Fees

These fees, if any, generally relate to assistance in connection with regulatory filings and accounting and disclosure consultation.

DELINQUENT SECTION 16(a) REPORTS

Section 16(a) of the Exchange Act requires directors and certain officers of the Company and owners of more than 10% of the Company's common shares to file an initial ownership report with the Securities and Exchange Commission and subsequent reports reflecting changes in their ownership of the Company's equity securities. The Company believes, based solely on a review of the copies of those reports furnished to the Company during the past year and written representations to it that no other reports were required, that during the period from July 1, 2018 through June 30, 2019 all filing requirements under Section 16 have been met except that Mr. Mills filed a late Form 4 report on June 11, 2018 to report the disposition of shares sold on December 28, 2017 pursuant to a tender offer by the Company commenced in November 2017 for $2,500,000 of shares which was open to all holders and was completed in December 2017.

COST OF SOLICITATION

The cost of solicitation of proxies will be borne by the Company. In addition to the use of the mails, proxy solicitations may be made by directors, officers, and employees of the Company, personally or by telephone or other means of communication, without receiving additional compensation. It is also anticipated that banks, brokerage houses, and other custodians, nominees and fiduciaries will be requested to forward soliciting material to their principals and to obtain authorization for the execution of proxies. The Company will reimburse banks, brokerage houses, and other custodians, nominees and fiduciaries for their out-of-pocket expenses.

REQUIREMENTS, INCLUDING DEADLINES, FOR SUBMISSION OF PROXY PROPOSALS, NOMINATION OF DIRECTORS AND OTHER BUSINESS OF SHAREHOLDERS

We plan to hold our 2020 annual meeting of shareholders during the month of November. Any proposal of a shareholder intended to be presented at the 2020 annual meeting of shareholders must be received by us for inclusion in the Proxy Statement and form of proxy for that meeting no later than June 19, 2020, 100 days before the anniversary of the date of this Proxy Statement. If any proposal is submitted after that date, we are not required to include it in our Proxy Materials. Any proposal of a shareholder intended to be presented at the 2020 annual meeting of shareholders that is not required to be included in the Proxy Statement and form of proxy must be received by us for that meeting no later than August 13, 2020, 45 days before the anniversary of the date of this Proxy Statement. Proposals should be submitted to the following address:

Corporate Secretary
SunLink Health Systems, Inc.
900 Circle 75 Parkway, Suite 1120
Atlanta, Georgia 30339

A notice of a proposed item of business should include a description of, and the reasons for, bringing the proposed business to the meeting, any material interest of the shareholder in the business, and certain other information about the shareholder.

Under our Code of Regulations, and as SEC rules permit, shareholders must follow certain procedures to nominate a person for election as a director at an annual or special meeting. Under these procedures, shareholders must submit the proposed nominee by delivering a notice to the Secretary of the Company at our principal executive offices. Normally, we must receive notice of a shareholder's intention to introduce a nomination at an annual meeting not less than 50 days nor more than 75 days before the next meeting. Assuming that our 2020 Annual Meeting of Shareholders is held on November 9, 2020, we must receive notice pertaining to the 2020 Annual Meeting no earlier than August 25, 2020 and no later than September 19, 2020. However, if we give less than 60 days' notice or public announcement of the annual meeting date, we must receive the notice no later than the close of business ten (10) days after the earlier of the date we first provide notice of the meeting to shareholders or announce it publicly.

If we hold a special meeting to elect directors with less than 60 days' notice, the effect of our Code of Regulations will be that we must receive a shareholder's notice of intention to introduce a nomination no later than the close of business ten (10) days after the earlier of the date we first provide notice of the meeting to shareholders or announce it publicly.

A notice of a proposed nomination must include certain information about the shareholder and the nominee, as well as a written consent of the proposed nominee to serve if elected.

WHERE YOU CAN FIND ADDITIONAL INFORMATION

WE HAVE MAILED, AND POSTED ON THE INTERNET, OUR 2019 ANNUAL REPORT TO SHAREHOLDERS IN CONNECTION WITH THIS PROXY SOLICITATION. IF YOU WOULD LIKE AN ADDITIONAL PHYSICAL COPY OF OUR 2019 FORM 10-K, EXCLUDING CERTAIN EXHIBITS, AT NO CHARGE, PLEASE CONTACT SUNLINK HEALTH SYSTEMS, INC., 900 CIRCLE 75 PARKWAY, SUITE 1120, ATLANTA, GEORGIA 30339. Copies of the Exhibits to the Annual Report on Form 10-K can be obtained by writing to the Corporate Headquarters at the address listed above, and enclosing $0.20 per page to cover photocopy expenses. Exhibits are also available through the SEC's EDGAR database, accessible on the Internet at www.sec.gov.

OTHER MATTERS

Admission to Meeting

All shareholders as of the record date, or their duly appointed proxies, may attend the meeting. Seating, however, may be limited. Admission to the meeting will be on a first-come, first-served basis. Please note that if you hold your shares in "street name" (that is, through a broker or other nominee), you will need to bring a copy of a brokerage statement reflecting your share ownership as of the record date. Only shareholders as of the record date may attend the meeting. Each shareholder may be asked to present valid picture identification, such as a driver's license or passport. Cameras, recording devices, cellular telephones, beepers, and other electronic devices will not be permitted at the meeting.

Action on Other Matters at the Annual Meeting

At this time, we do not know of any other matters to be presented for action at the Annual Meeting other than those mentioned in the Notice of Annual Meeting of Shareholders and referred to in this Proxy Statement. If any other matter properly comes before the meeting, it is intended that the proxies will be voted in respect thereof in accordance with the judgment of the persons voting the proxies.

Shareholders are urged to vote their shares via the Internet or telephone or to date, sign and return promptly the enclosed proxy in the accompanying envelope, which requires no postage if mailed in the United States. Your cooperation is appreciated. Your proxy will be voted, with respect to the matters identified thereon, in accordance with any specifications on the proxy.

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, 2019

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 **(State or other jurisdiction of incorporation or organization)**	**31-0621189** **(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	Trading Symbol	Name of each Exchange on which registered
Common Shares without par value	SSY	NYSE American, LLC
Preferred Share Purchase Rights	-	-

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 every Interactive Data File required to be submitted 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 such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth 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 26, 2019, there were 6,986,855 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, 2018 of the registrant's common shares as reported by NYSE American stock exchange amounted to $4,884,050.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Shareholders of SunLink Health Systems, Inc., scheduled to be held on November 11, 2019, 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, 2019.

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 the 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. Hospital and nursing home, 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 and drug 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

- the 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 or pay principal on 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, employment, fiduciary and other liability insurance;
- the efforts of insurers, healthcare providers, and others to contain healthcare costs;
- the impact on hospital, clinic and nursing home services of the treatment of patients in alternative or lower acuity healthcare settings, such as with drug therapy or in surgery centers, and urgent care centers, retirement homes or at home;
- changes in medical and other technology;
- changes in estimates of self-insurance claims and reserves;
- changes in prices of materials and services utilized in our Healthcare Services 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, clawbacks, processes, and conditions relating to our Pharmacy segment imposed by pharmacy benefit managers, drug manufacturers, and distributors.

Liabilities, Claims, Obligations and Other Matters

- claims under leases, guarantees, disposition agreements, and other obligations relating to asset sales or discontinued operations, including claims from sold or leased facilities and 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 tornados, 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 relating to reimbursement terms;
- the decision by Mississippi (where we operate our remaining hospital and nursing home) 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 and enforcement interpretations of such 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 of cash and the 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, an IT service company based in Georgia, and a healthcare facility which is partially leased to a third parties. Our Pharmacy segment subsidiary owns and 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 improving the operations, services and profitability of its existing Healthcare Services and Pharmacy businesses while seeking to sell certain of its subsidiaries’ underperforming assets.

The Company has used a portion of the cash proceeds from recent dispositions of assets to pay down debt and certain other liabilities, to repurchase common shares, including tender offers completed in February and December 2017, a private purchase and open market repurchases of its common shares in December 2018, and to make improvements to its Healthcare Services and Pharmacy businesses. The Company may also use existing cash, as well as any net proceeds from future dispositions, if any, to, among other things, 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, Pharmacy or other 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.

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 a medical office building and approximately four (4) acres of land in Clanton, Alabama. A portion of the medical office building is currently rented to two separate third parties.
- 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, SunLink Health Systems Technology (SHS Technology), which provides information technology services (IT) to outside customers and to SunLink subsidiaries.

Pharmacy

The Pharmacy segment is composed of four operational areas:

- Retail pharmacy products and services, consisting of two retail pharmacy operations 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, assisted living facilities, behavioral and 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.

Trace receives payments for patient care from Federal Medicare programs, State Medicaid programs, private insurance carriers, health maintenance organizations, preferred provider organizations, TriCare, and from employers and patients directly. Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons and persons with end-stage renal disease. Medicaid is a federal-state program, administered by the states, that provides hospital and nursing home benefits to qualifying individuals who are unable to afford care. Trace is certified as a healthcare services provider for persons covered by Medicare and Medicaid programs. TriCare is a federal program for the healthcare of certain U.S. military personnel and their dependents. 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 other third-party payors. Further, amounts received under the Medicare and Medicaid programs generally are significantly less than the established charges of our facilities. 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 homes is subject to fixed payments under the Medicare prospective payment systems. In accordance with Medicare laws, the Centers for Medicare and Medicaid Services (‘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’s 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 the state in which we operate a nursing home 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 hospital or nursing home 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 Management Teams

Each of our businesses is managed by a subsidiary officer who is supported by other professional personnel as needed, 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, licensed pharmacists, licensed pharmacy technicians, IT staff, and business office managers. Staff size and composition vary depending on the size and occupancy or volume of activity of each businesses, the types of services provided and the acuity level of the patients and residents. The nursing home contracts with physicians who provide medical director services and serve on performance improvement committees. Our businesses purchase certain services including information systems from an affiliate and obtain certain services such as legal, finance, accounting, purchasing, human resources and facilities management support, from vendors recommended by SunLink.

Quality Assurance

Quality of care and services 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 implements quality assurance procedures to monitor the level and quality of care provided to patients and has a medical director who supervises and is responsible for the quality of medical care so provided, as well as 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 periodically conducts surveys of their patients, either during their stay or subsequently, to identify potential areas of improvement. Trace is accredited by The Joint Commission ("JCAHO").

Our pharmacy business maintains quality assurance procedures under the direction of licensed pharmacists-in-charge ("PIC") including, among other procedures, regular inventories and reconciliations of drugs by a PIC who is supported by pharmacy technicians.

Competition

Among the factors which we believe influence patient and customer selection in our healthcare businesses are the appearance and functionality of the facilities; the quality and demeanor of professional staff, physicians and pharmacists; and the participation of our businesses 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 competes 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 home. 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. Our Floy Dyer Nursing Home is located adjacent to our Trace Regional Hospital.

Our Carmichael's Pharmacy competes with retail and institutional pharmacies, home health providers, and DME providers, including national chains with vastly more resources and larger distribution systems than our, as well as with local pharmacies with strong reputations with the community. We compete primarily on the basis of location, service, participation in pharmacy reimbursement and benefit plans, and reputation. Our retail pharmacy business seeks to provide non-pharmacy items such as snacks, gifts and merchandise to customers who visit our pharmacy, and our local staff are generally long-time community residents known to many of our pharmacy customers. We believe our personal service approach provides us the ability to compete with larger pharmacy chains which operate larger stores and provide more merchandise offerings.

SHS Technology 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. SHS Technology does not sell hardware or software. SHS Technology'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 SHS Technology provides is intense and some potential customers operate on legacy IT systems which make it difficult to change to systems which SHS Technology is able to support.

Managed Care

Our subsidiaries are affected by their ability to negotiate service contracts with purchasers of group healthcare services. HMOs, PPOs and pharmacy benefit managers attempt to direct and control the use of healthcare products, drugs and 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 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 patients in our hospital and pharmacy communities are covered by managed care or other reimbursement programs, all of which generally pay less than established charges for products and 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 drugs and 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, 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 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.

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. 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 1.3%, 1.85% and 3.1% for FFY 2018, 2019, and 2020, respectively, which includes the following market basket update: FFY 2018 1.35%, FFY 2019 1.35% and FFY 2020 2.7%. 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 the provisions of 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, 2022.
- 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 50% of the market basket update in FFY 2018, by 61% of the market basket rate in FFY 2019 and 90% in FFY 2020. Our subsidiary hospital did not attest as a meaningful electronic records user for FFYs 2019, 2018 or 2017.

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 group 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 calendar year 2019, the update factor was 2.0%. For calendar year 2020, the update factor is currently proposed to be 2.7%. 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 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 less than 1% of our healthcare services net patient service revenues for the years ended June 30, 2019 and 2018.

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 state in which SunLink currently operates its Healthcare Services hospital and nursing home has implemented initiatives to decrease the Medicaid funds paid to providers. Medicaid pays providers for inpatient services in a manner similar to the Medicare prospective payment system in that hospitals receive a fixed fee for inpatient hospital services based on the established fixed payment amount per discharge for categories of hospital treatment, also known as DRGs. These Medicaid DRG payments do not consider a specific hospital’s costs, but are statewide rates adjusted for each 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.

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 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 allows all states to establish programs to contract with RACs by 2011. Currently the state where our subsidiary operates has RAC programs, and our Healthcare Services hospital and nursing home have had requests from the 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 have routinely appealed RAC overpayment determinations. Under the RAC program, our Healthcare Services facilities have experienced losses in the aggregate from audit adjustments of approximately $11 and $48 for the fiscal years ended June 30, 2019 and 2018.

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 has increased federal funding for the MIC program since FFY 2011. In addition to RACs and MICs, the state Medicaid agencies and other contractors have also increased their review activities.

Government Reimbursement Programs—Nursing Homes

Medicare —The Medicare Part A program provides reimbursement for extended-care services furnished to Medicare beneficiaries who are admitted to nursing homes 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 homes. Medicare payments to our nursing home 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 ("MMA") implemented a major expansion of the Medicare program through the introduction of a prescription drug benefit ("Medicare Part D"). 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 home 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 homes 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 homes are ranked according to performance on this preventable hospital readmission rate, with corresponding incentive payments based upon such ranking. CMS also reduced the Medicare per diem rate by 2% beginning October 1, 2018 in connection with the launch of this initiative.

Effective October 1, 2019, CMS will replace the prospective payment system for skilled nursing facilities, RUG, with a new prospective payment system called Patient-Driven Payment Model ("PDPM"). PDPM bases payment on resident characteristics rather than on services provided. Each resident's reimbursement depends on the summations of five case–mix adjusted components (physical therapy, occupational therapy, speech language pathology, nursing, and nontherapy ancillaries), each with its own case-mix groups; application of a variable per day adjustment schedule, which reduces the daily payment for three of the case-mix categories on a sliding scale; and addition of these sums to the non-case-mix adjusted component. PDPM uses the five-day resident assessment for determining the Medicare rate for the resident's entire Part A stay, eliminating the RUG requirement for additional assessments on days 14, 30, 60 and 90. The rule allows a skilled nursing facility ("SNF") to reclassify a resident after the five-day assessment under an optional Interim Payment Assessment ("IPA") but CMS has not yet defined criteria for triggering an IPA.

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.

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 nursing home provides 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 nursing home. 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, Mississippi is experiencing budgetary pressures which have resulted in further reductions to Medicaid payments to our nursing homes.

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 home.

In addition, some states (including Mississippi) 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 home 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 home seeks to maximize the number of nongovernment payment residents it admits, including those covered under private insurance and managed care health plans, nongovernment payment residents in our nursing home 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 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, Two and Round Two Recompete 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 December 13, 2016, among other things, reinstated the January 1, 2016 reimbursement rates for competitive bid items in non-competitive bidding areas retroactively for the applicable July 1, 2016 through December 31, 2016 Medicare claims. Accordingly, the impact of the Cures Act led to increased reimbursement for the Pharmacy segment. This legislation contained no provisions to defer or change reimbursement rates effective as of January 1, 2017 and prospectively thereafter, and it does not include any changes to rates in competitive bidding areas. In addition, all DMEPOS CBP contracts expired on December 31, 2018. Accordingly, as of January 1, 2019, a temporary gap exists in the entire DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020. On March 7, 2019, CMS announced plans to consolidate the CBAs included in the Round 2 Recompete and the Round 1 2017 DMEPOS CBP into a single round of competition named Round 2021. Round 2021 contracts are scheduled to be effective on January 1, 2021 and extend through December 31, 2023. We cannot assure you that our Pharmacy segment will be able to operate its DMEPOS and enteral nutrition products operations profitably in the future at the current reimbursement rates. The MMA also created a Medicare prescription drug benefit (which began in 2006) and a prescription drug card program. Final rules implementing the portions of the MMA relating to the prescription drug benefit were adopted in 2005.

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

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

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

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

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

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

Non-government Reimbursement Arrangements—Pharmacy

Major insurance and commercial payors for pharmacy products and services have taken significant steps in recent years to reduce payments for pharmacy products and services and to reduce the involvement of independent pharmacies in an effort to reduce costs and aggregate product distribution into larger volumes in an effort to better bargain prices with pharmacy manufacturers. In addition, pharmacy benefit managers have evolved to act as the intermediary between payors and patients and they also attempt to limit the prices and involvement of independent pharmacies. Also, large retailers, both pharmacy and general retailers, such as Walgreens, CVS and Wal-Mart have established bulk purchasing arrangements with pharmacy manufacturers and exclusive or limited participation agreements with pharmacy benefits managers to reduce the costs and volume of drugs provided by independent retail pharmacies. Further, e-commerce sites, such as Amazon and PillPack, are actively seeking to provide pharmaceuticals and DMEPOS products directly to patients via online ordering and remote fulfillment. These non-government reimbursements arrangements have had a negative effect on our Pharmacy segment. Our pharmacy locations seek to counteract these pressures by providing greater services and convenience locally than is provided by remote pharmacy providers. However, there can be no assurance that these non-government reimbursement arrangements will not have an increasingly negative impact on our Pharmacy segment revenues and profitability in the future.

HEALTHCARE REGULATION

Overview

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

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

Healthcare Facility Regulation

<u>Certificate of Need Requirements</u>

A number of states require approval for the purchase, construction or expansion of various healthcare facilities, including findings of need for additional or expanded healthcare services. Certificates of Need (“CONs”), which are issued by governmental agencies with jurisdiction over applicable healthcare facilities, are at times required for capital expenditures exceeding a prescribed amount, changes in bed capacity or the addition of services and certain other matters. The state in which a SunLink subsidiary currently operates a hospital and a nursing home (Mississippi) has a CON law that applies to such facility. States periodically review, modify and revise their CON laws and related regulations. Any violation of state CON laws can result in the imposition of civil sanctions or the revocation of licenses for such facilities. SunLink is unable to predict whether its Healthcare Services subsidiaries’ will be able to obtain any CONs that may be necessary to accomplish their business objectives in any jurisdiction where such certificates of need are required.

<u>Utilization Review Compliance and Hospital Governance</u>

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

Emergency Medical Treatment and Active Labor Act

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

Pharmacy Segment Regulation

Overview

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

Pharmaceutical Distribution

The Pharmacy subsidiary conducts the operations of our Pharmacy segment. In addition to retail pharmacy walk-in customers, it distributes pharmaceuticals through a variety of delivery methods, including by mail and express delivery services. Many states in which our Pharmacy segment delivers or may seek to deliver pharmaceuticals have laws and regulations that require out-of-state mail service pharmacies to register with, or be licensed by, the boards of pharmacy or similar regulatory bodies in those states. These states generally permit the dispensing pharmacy to follow the laws of the state within which the dispensing pharmacy is located.

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 the Pharmacy operations of the Pharmacy segment, 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 the Pharmacy operations of the Pharmacy segment, they could have an adverse effect on its ability to expand our pharmacy operations, which currently are concentrated in Louisiana. A number of state Medicaid programs prohibit the participation in such state's Medicaid program by either out-of-state retail pharmacies or mail order pharmacies, whether located in-state or out-of-state.

Advertising and Marketing Regulations

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

General Healthcare Regulations

Drugs and Controlled Substances

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

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

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

Participation in the Medicare and/or Medicaid programs is heavily regulated by federal statutes and regulations. If a Healthcare Services or Pharmacy segment operation fails to comply substantially with the numerous federal laws governing such activities, participation in the Medicare and/or Medicaid programs by the applicable subsidiary or even SunLink generally may be terminated and/or civil or criminal penalties may be imposed. For example, a hospital may lose its ability to participate in the Medicare and/or Medicaid programs if it makes claims to Medicare and/or Medicaid for services not provided or misrepresents actual services provided in order to obtain higher payments; pays money to induce the referral of patients or the purchase of items or services where such items or services are reimbursable under a federal or state health program; fails to report or repay improper or excess payments; or fails to provide appropriate emergency medical screening services to any individual who comes to a hospital's campus or otherwise fails to properly treat and transfer emergency patients.

Hospitals continue to be one of the primary focus areas of the Office of the Inspector General ("OIG") of the United States and other governmental fraud and abuse programs and the OIG has issued and periodically updates compliance program guidance for hospitals. Each federal fiscal year, the OIG also publishes a General Work Plan that provides a brief description of the activities that the OIG plans to initiate or continue with respect to the programs and operations of the Department of Health and Human Services ("HHS") and details the areas that the OIG believes are prone to fraud and abuse.

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

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

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

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

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

The Federal False Claims Act and Similar State Laws

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

HIPAA Transaction, Privacy and Security Requirements

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

A violation of the HIPAA regulations could result in civil money penalties of $1 per incident, up to a maximum of $25 per person, per year, per standard violated. HIPAA also provides for criminal penalties of up to $50 and one year in prison for knowingly and improperly obtaining or disclosing protected health information, up to $100 and five years in prison for obtaining protected health information under false pretenses and up to $250 and ten years in prison for obtaining or disclosing protected health information with the intent to sell, transfer or use such information for commercial advantage, personal gain or malicious harm. Since there is limited history of enforcement efforts by the federal government at this time, it is difficult to ascertain the likelihood of enforcement efforts in connection with the HIPAA regulations or the potential for fines and penalties, which may result from any violation of the regulations.

HIPAA Privacy Regulations

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

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

HIPAA Electronic Data Standards

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

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

HIPAA Security Standards

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

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

HIPAA National Provider Identifier

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

Medical Waste Regulations

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

Regulatory Compliance Program

Our subsidiaries maintain compliance programs under the direction of a risk manager. The compliance programs are directed at all areas of regulatory compliance, including physician recruitment, reimbursement and cost reporting practices, as well as Pharmacy segment operations. Our Healthcare Services and Pharmacy segments' operations each have one or more compliance officers and develops remediation plans to correct problems should they arise. In addition, all employees are provided with a copy of and given an introduction to the subsidiary's *Code of Conduct*, which includes ethical and compliance guidelines and instructions about the proper resources to utilize in order to address any concerns that may arise. Each Healthcare Services and Pharmacy segment operations conduct annual training to re-emphasize its *Code of Conduct* and monitor its compliance program to respond to developments in healthcare regulations and the industry. A toll-free hotline is also maintained to permit employees to report compliance concerns on an anonymous basis.

Professional Liability

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

The recorded liability for professional liability risks of our subsidiaries' operations includes an estimate of liability for claims, including claims retained after the disposition of any facility or operations or claims assumed in connection with the acquisition of any facility or operations. These estimates are based on actuarially determined amounts.

Environmental Regulation

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

INFORMATION ABOUT OUR EXECUTIVE OFFICERS

Our executive officers, as of September 27, 2019, 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	70
Mark J. Stockslager	Chief Financial Officer and Principal Accounting Officer	60
Byron D. Finn	President—SunLink ScriptsRx, LLC	69

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

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

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

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

Item 1A. *Risk Factors*

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

Consolidated Operations Risks

If our operations continue to generate operating losses, we may not be able to generate sufficient cash flows to meet our liquidity needs.

We rely upon cash on hand, cash from operations, and cash from asset sales to fund our cash requirements for working capital, capital expenditures, commitments, and payments of principal and interest on borrowings. Our ability to generate cash from operations has been negatively impacted by reduced federal and state reimbursements, managed care efforts (including restrictions, limitations, administrative requirements and clawbacks in both our Healthcare Services and Pharmacy businesses), uncollectible self-pay net revenues of our Healthcare Services segment, increased salary expenses for employed physicians, and decreased patient volume at our facilities as a result of economic conditions in the locations we serve, as well as by decreased sales volume and earnings experienced by certain lines of business in our Pharmacy segment, and by our corporate overhead. A substantial portion of corporate overhead is incurred because we are a public company with limited operations. We expect that these factors will continue to have a negative impact on our business for the foreseeable future. Further deterioration would negatively impact our results of operations and cash flows.

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

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

Indebtedness of one of our subsidiaries which we have guaranteed could be subject to prepayment which could require a substantial amount of our cash and any such repayment could restrict our current and future operations, which could negatively affect our ability to manage our operations and liquidity.

The RDA loan at our Trace subsidiary contains various terms and conditions, including financial restrictions and limitations, and affirmative and negative covenants. The loan is guaranteed by SunLink. At June 30, 2019, Trace was not in compliance with the debt service coverage, fixed charge coverage and funded debt to EBITDA ratios. The Company is discussing with the lender a waiver of this non-compliance but a waiver of non-compliance has not been received as of the date of the filing of this report. Since Trace was in non-compliance with these covenants at a measurement date, if the lender were to declare an event of default and accelerate the maturity of the indebtedness, either Trace or SunLink under its guarantee could be required to repay the loan in advance of its maturity which would require a substantial amount of our cash and any such repayment could restrict our current and future operations, which could negatively affect our ability to manage our operations and liquidity. No event of default has been declared by the lender as of the date of the filing of this report nor is such declaration currently anticipated.

Healthcare reform initiatives have resulted in significant changes to the United States healthcare system some of which may adversely affect our business.

Healthcare reform initiatives, including the enactment of the ACA, managed Medicaid initiatives, and commercial managed healthcare programs (including those relating to acute care services, diagnostic procedures and tests, laboratory services, drug formularies, pharmacy dispensing, and other programs) have impacted each of our businesses in some manner. The reforms are very significant and, ultimately, could further change the nature of our services, the methods and amounts of payment for our services, and the underlying regulatory environment.

In general, a primary goal of recurrent efforts at healthcare reform is to reduce the cost to federal and state governments of reimbursement to providers under various governmental programs, which includes reductions in the reimbursement paid to us and other healthcare providers. Moreover, healthcare reform could negatively impact insurance companies, other third-party payors and our customers, as well as other healthcare providers, which may in turn negatively impact our business. As such, healthcare reforms and changes resulting from the ACA, as well as other similar healthcare reforms, could have a material adverse effect on our business, financial position, results of operations, and liquidity.

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

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to licensure; conduct of operations including patient referrals, physician recruiting practices, pharmacy operations, cost reporting and billing practices; ownership, condition and operation of facilities; addition of facilities and services; confidentiality, maintenance, and security issues associated with medical records; billing for services; and prices for services.

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

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

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

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.

Due to the "opioid crisis", the Drug Enforcement Administration ("DEA") has added regulations and increased its scrutiny of drug dispensing at both the retail and wholesale level. As a result, physicians and pharmacists are more cautious about dispensing certain drugs and wholesalers monitor drug purchases by their customers. In addition, wholesalers are more closely monitored by the DEA and may limit the volume and delivery of drugs.

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

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

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

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

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

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

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

Reforms in Pharmacy distribution and dispensing have impacted and may further impact our Pharmacy business

Pharmacy benefit managers have undertaken a number of actions, primarily in an effort to reduce cost, which have impacted our pharmacy business. These actions include limiting reimbursable drug formularies, requiring outcome and quality reporting, and implementing claw backs, takebacks and penalties for noncompliance with various contract terms, some of which may not be known at the time a prescription is filled. In addition, pharmacy benefit managers and manufacturers have limited the drugs which independent pharmacies (including our pharmacy subsidiary) may dispense and receive reimbursement for; and in some cases have determined not to contract with independent pharmacies for dispensing services at all, preferring to provide "direct-to-consumers" type distribution. In addition, the recent purchase or merger of pharmacy benefit companies and insurance companies effectively allows the combined business to control distribution, dispensing, pricing and payment of drugs from the manufacturer to the consumer. This "vertical integration" of the pharmacy distribution and dispensing system in the United States could have the effect of eliminating independent pharmacies, limiting the drugs available for dispensing to patients, and may reduce prices below dispensing costs. Any of these pharmacy reforms could result in an adverse effect on our pharmacy business.

General economic conditions.

Much healthcare spending is discretionary and can be significantly impacted by economic downturns. When patients are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. In addition, employers may impose or patients may select a high-deductible insurance plan or no insurance at all, which increases a hospital's dependence on self-pay revenue.

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

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

Our subsidiaries are subject to potential claims for professional liability (medical malpractice) in connection with current operations, as well as potentially acquired or discontinued operations. To cover such claims, professional malpractice liability insurance and general liability insurance is maintained in amounts believed to be sufficient for operations, although some claims may exceed the scope or amount of the coverage in effect. However, SunLink currently purchases limited insurance policies to cover discontinued operations exposures. We may purchase such insurance in the future at levels providing for the retention of more risk by us and at lower aggregate limits. The assertion of a significant number of claims, either within a self-insured retention (deductible) or individually or in the aggregate in excess of available insurance, could have a material adverse effect on our results of operations or financial condition. Premiums for professional liability insurance have historically been volatile, and we cannot assure you that professional liability insurance will continue to be available on terms acceptable to us, if at all. The operations of our hospital and pharmacies also depend on the professional services of physicians, pharmacists 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 our subsidiaries' hospital, pharmacies, 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.

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.

Risks Related to Our Operations

SunLink has a limited staff of corporate employees and depends heavily on its corporate staff and subsidiaries' management personnel; the loss of the services of one or more of SunLink's key personnel could weaken SunLink's management team and impair its ability to deliver healthcare services and pharmacy products and services.

The success of our operations depends on the ability to attract and retain managers, related health care employees and information technology staff, as well as on the ability of subsidiary-based officers and key employees to manage growth successfully. SunLink's subsidiaries have been able to attract healthcare subsidiary management; however, if the subsidiaries or corporate staff is unable to attract and retain effective management, the operating performance could decline.

SunLink's success depends on the ability of our operating subsidiaries to attract and retain qualified healthcare professionals. A shortage of qualified healthcare professionals including physicians, mid-level healthcare practitioners (such as physician assistants, or nurse practitioners) and pharmacists in any of our markets could weaken the ability of our subsidiaries to deliver healthcare services.

In addition to the management personnel which each subsidiary employs, our Healthcare Services operations are dependent on the efforts, ability, and experience of our healthcare professionals, such as physicians, nurses, therapists, pharmacists and lab technicians. Nurses, pharmacists, lab technicians and other healthcare professionals are generally employees of an individual subsidiary. Each subsidiary'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 one of our 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 the operating performance of one or more of our subsidiaries to decline.

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

A significant portion of SunLink's consolidated revenues are derived from the Medicare and Medicaid programs, which are highly regulated and subject to frequent and substantial changes. Approximately 70% of net consolidated revenues was derived from the Medicare and Medicaid programs for the year ended June 30, 2019. 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, pharmacy services and costs. Mississippi has not expanded Medicaid or set-up exchanges.

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

Revenue and profitability of our subsidiaries' operations may be constrained by future cost containment initiatives undertaken by purchasers of such services.

Our subsidiaries' 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, pharmacy benefit managers and employers, to revise payment methodologies and monitor healthcare expenditures in order to contain healthcare costs. Our community hospital operations derived approximately 19% of their consolidated net patient revenues for the fiscal year ended June 30, 2019 from private payors and other non-governmental sources who contributed less than 5% of consolidated patient days. Initiatives such as managed care organizations offering prepaid and discounted medical services packages, have adversely affected hospital revenue growth throughout the country and such packages represent an increasing portion of our subsidiary's hospital's admissions and outpatient revenues and have resulted in reduced revenue growth at our current and former subsidiaries' hospitals. In addition, private payors increasingly are attempting to control healthcare costs through direct contracting with hospitals to provide services on a discounted basis, increased utilization review and greater enrollment in managed care programs such as health maintenance organizations and preferred provider organizations, referred to as PPOs. If our subsidiaries, specifically our hospital subsidiary operations, are unable to contain costs through increased operational efficiencies and the trend toward declining reimbursements and payments continues, the results of our Healthcare Services 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 Services operations face intense competition from other hospitals and nursing homes which directly affect such segment and consolidated revenues and profitability.

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

Trace's nursing home also competes 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 do not offer. 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.

The Healthcare Services business is highly competitive and competition among hospitals, nursing homes and other healthcare providers for patients has intensified in recent years. Some of these competing facilities offer services which are not offered by SunLink's subsidiaries' facilities. Some of the competing facilities 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. SunLink's subsidiaries also face competition from other for-profit healthcare companies, some of which have substantially greater resources, as well as other providers, such as outpatient surgery and diagnostic centers and home health agencies.

The intense competition from other providers of Healthcare Services directly affects the market share of our subsidiaries' facilities, as well as their and our revenues and profitability.

Changes in market demographics may increase competition for certain of our Healthcare Services subsidiaries.

We cannot assure you that we will have the financial resources to fund capital improvements to our Trace facility or any other subsidiary, which may face additional competition, or that even if financial resources are available to us, that 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 our revenues through lower utilization, increased difficulty in the recruitment of physicians or other service providers and otherwise as a result of increased competition.

SunLink's subsidiaries' Healthcare Services may be subject to, and depend on, certificate of need laws which could affect their ability to operate profitably.

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

In addition, the elimination or modification of CON laws in Mississippi where SunLink's subsidiary operates or in the future may operate covered healthcare services, could subject such facilities to greater competition making it more difficult to operate profitably.

The success of SunLink's hospital subsidiary depends upon that subsidiary's hospital's ability to maintain good relationships with the physicians and, if the hospital is unable to successfully maintain good relationships with physicians, admissions and outpatient revenues may decrease and operating performance could decline.

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

Changes in the laws and regulations regarding payments for hospice services and "room and board" provided to hospice patients residing in skilled nursing facilities could reduce our net patient service revenue and profitability.

For hospice patients receiving nursing home care under certain state Medicaid programs who elect hospice care under Medicare or Medicaid, the state must pay, in addition to the applicable Medicare or Medicaid hospice per diem rate, an amount equal to at least 95% of the Medicaid per diem skilled nursing facility rate for "room and board" furnished to the patient by the skilled nursing facility. The reduction or elimination of Medicare payments for hospice patients residing in skilled nursing facilities could adversely affect the revenues of our skilled nursing facility.

Risks Relating to our Pharmacy Operations

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

For the year ended June 30, 2019, the operations of our Pharmacy segment derived approximately 65% of its net revenues from government payors, principally Medicare and Medicaid. The Deficit Reduction Act of 2005 exempted rural providers of home care related services from the competitive acquisition program to which urban providers are subject.

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

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

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

Louisiana, where our Pharmacy segment operates, has implemented a managed Medicaid program which is administered by outside contractors. These managed Medicaid programs are designed to reduce the State's administrative costs and the cost of the products and services provided to beneficiaries.

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

The Pharmacy segment is currently subject to the expanded provisions of the Medicare competitive bidding program which have had a negative impact on the prices we receive for durable medical equipment. The current provisions could be expanded or changed in the future. Any additional changes in government reimbursement or payment amounts could have a further adverse effect on our consolidated results of operations.

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

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

The operations of our Pharmacy segment are highly dependent on our relationship with and the stability of one key supplier, and the loss of such key supplier could adversely affect the business of the Pharmacy segment.

Any termination of, or adverse change in, our relationships with our key supplier, or the loss of supply of one of our key products for any other reason, could have a material adverse effect on the business of the Pharmacy segment and our consolidated results of operations. The largest supplier for the Pharmacy segment accounted for approximately 77% of the segment's cost of goods sold in the fiscal year ended June 30, 2019. In addition, the Pharmacy segment has few long-term contracts with its suppliers. Arrangements with most of its suppliers may be canceled by either party, without cause and on minimal notice; and many of these arrangements are not governed by written agreements.

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

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

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

Changes in average wholesale prices ("AWP") could reduce our pricing and margins.

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

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

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

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

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

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

The Pharmacy segment market may grow slower than expected, which could adversely affect our revenues.

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

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

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

Other Risks

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

Historically, our available capital has been sufficient to meet our operating expenses, lease obligations, debt service requirements, and capital expenditures, and we have managed our liquidity such that our aggregate unrestricted cash at June 30, 2019, was $7,742. Future circumstances could require us to materially increase our revenues, materially reduce our expenses, or otherwise materially improve operating results, dispose of existing assets or obtain material new sources of capital in order to maintain adequate liquidity.

The Company is currently limited in its ability to raise capital, debt or equity, in the public or private markets on what it considers acceptable terms. Trace has been able to borrow money through facility based mortgages, each of which is guaranteed by the Company, utilizing USDA Rural Development Authority guaranties, (“RDA Loan”). The Company and its subsidiaries currently must fund working capital needs from cash from operations or from the sale of additional assets, and we cannot assure you that we would be successful in improving our results of operations, reducing our costs, obtaining additional credit facilities or selling additional assets.

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

From time to time, the Company has considered the advisability of deregistering its common shares under the Exchange Act. In the event the Company was able to deregister its common shares under the Exchange Act, holders of our securities would be subject to the risks of an investment in a private rather than a public company. Upon any such deregistration of our shares, our duty to file periodic reports with the SEC would be suspended for as long as we had fewer than 300 record shareholders, and we would no longer be a public reporting company. In addition, we would be relieved of the obligation to comply with the requirements of the proxy rules under Section 14 of the Exchange Act. When and if the Company were to deregister, SunLink shares would no longer be listed on the NYSE American, LLC stock exchange, and there might not be a sufficient number of shares outstanding and publicly traded following any deregistration to ensure a continued trading market in the shares in any over-the-counter market. The continued quotation of our common shares as well as the availability of any over-the-counter trading in our common shares would depend, in part, on the nature and extent of continued publicly available information about SunLink. Shareholders also could be adversely affected by a reduction in our “public float,” that is, the number of shares owned by outside shareholders and available for trading in the securities markets, especially if the Company makes future tender offers or private or open market purchases of its common shares. The suspension of our reporting obligations under the Exchange Act might further reduce the existing limited trading market for the Company’s shares and may result in a decline in the price of the Company’s shares and reduced liquidity in any trading market for our shares in the future. We might also have less access to capital markets and not be able to use the Company’s shares to effect acquisitions as a non-reporting company. Although the Company is not currently pursuing an effort to deregister our common shares under the Exchange Act, there is no assurance that our Board may not again determine to pursue going private in the future.

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 Annual Report under “*Forward-Looking Statements*.”

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

None.

Item 2. ***Properties***

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

Name or function (licensed beds)	Location City and State	Square Footage		Date of Acquisition/ Lease Inception	Ownership Type
Healthcare Services					
Trace Regional Hospital (84)	Houston, MS	76,344		February 1, 2001	Owned
Floy Dyer Nursing Home (66)	Houston, MS	32,700		February 1, 2001	Owned
Careside Medical Park	Clanton, AL	16,563	(5)	February 1, 2001	Owned
Houston, MS land	Houston, MS	5.3 acres	(1)	February 1, 2001	Owned
Pharmacy Operations					
Carmichael's Cashway Pharmacy, Inc.	Crowley, LA	22,500	(2)	April 22, 2008	Leased
Carmichael's Cashway Pharmacy, Inc.	Lafayette, LA	7,244	(3)	April 22, 2008	Leased
Carmichael's Cashway Pharmacy, Inc.	Lake Charles, LA	7,808	(4)	April 22, 2008	Leased
Carmichael's Cashway Pharmacy, Inc.	Lafayette, LA	545	(7)	March 31, 2015	Leased
Corporate Offices	Atlanta, GA	4,800	(6)	June 1, 1998	Leased

(1) This property is currently vacant.
(2) Lease of approximately 20,100 square feet of store location, warehouse and office space. The lease expires in March 2021 and provides for a renewal of the lease for a five-year term. Includes an additional lease, commencing in June 2018, of approximately 2,400 square feet of off-site warehouse space. This lease expires in May 2020 and provides for a renewal of the lease for a two-year term.
(3) This lease is for a store location and warehouse space. It expires in October 2020 and provides for renewal of the lease for a five-year term.
(4) This lease is for a store location and warehouse space and expires in December 2021.
(5) The building is currently partially rented to two tenants.
(6) This lease is for office space for corporate staff and SunLink Health Systems Technology. The lease expires in June 2020.
(7) This lease is for a store location in a medical office building and expires in August 2021.

Item 3. ***Legal Proceedings***

The Company and its subsidiaries are subject to various claims and litigation that arise from time to time in the ordinary course of business, including, among other things, tax, contract, workers compensation and medical malpractice claims and litigation. Medical malpractice and certain other claims are generally covered by malpractice, general liability or other insurance but are subject to provisions under which the Company retains a portion of the risk, which retention, particularly in the case of claims of medical malpractice, can be material. Based on current knowledge, the Company's management does not believe that current pending claims and litigation will have a material adverse effect on the Company's consolidated financial position or its liquidity. However, in light of the uncertainties involved and indeterminate damages sought in some such claims and litigation, an adverse outcome could be material to our results of operations or cash flows in any reporting period.

Included in the Company's Form 10-Q for the third quarter of 2019 was the disclosure that the Company had received notice from the United States Internal Revenue Service ("IRS") of a $752,000 proposed civil penalty for a failure by a now dormant subsidiary to properly and timely file in a prior year appropriate form W-2s. After a hearing, this matter was resolved by payment by the Company of a nominal amount.

Item 4. ***Not Applicable***

PART II

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

SunLink common shares are listed on the NYSE American, LLC exchange. SunLink's ticker symbol is "SSY". As of June 30, 2019, there were approximately 306 registered holders of SunLink common shares.

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 has historically retained its earnings for use in the operation and improvement of its business and for other corporate purposes. While the Company currently does not anticipate declaring or paying regular cash dividends in the foreseeable future, the board of directors has discussed returning capital to shareholders from funds derived from asset sales or otherwise. Any future determination to declare or pay cash dividends will be made 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 at this time.

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

This Annual Report and the documents that are incorporated by reference in this Annual Report contain certain forward-looking statements within the meaning of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995. Forward-looking statements include all statements that do not relate solely to historical or current facts and may be identified by the use of words such as "may," "believe," "will," "seeks to", "expect," "project," "estimate," "anticipate," "plan" or "continue." These forward-looking statements are based on the current plans and expectations and are subject to a number of risks, uncertainties and other factors which could significantly affect current plans and expectations and our future financial condition and results. For a listing and a discussion of such factors, which could cause actual results, performance and achievements to differ materially from those anticipated, see Certain Cautionary Statements—Forward Looking Information and Item 1A.

Critical Accounting Estimates

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

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

The table of critical accounting estimates that follows is not intended to be a comprehensive list of all of our accounting policies that require estimates. We believe that of our significant accounting policies, as discussed in Note 2 of our Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K for the fiscal year ended June 30, 2019, the estimates discussed below involve a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and financial condition.

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

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Receivables-net and Provision for Concession Adjustments		
Receivables-net for our Healthcare Services segment primarily consists of amounts due from third-party payors and patients from providing healthcare services to healthcare facility patients. Receivables-net for our Pharmacy segment primarily consists of amounts due from third-party payors; institutions such as nursing homes, home health, hospice, hospitals; Medicaid Part D program; and customers from the sale of pharmacy services and merchandise. Our ability to collect outstanding receivables is critical to our results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for concession adjustments to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty lies with accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. Our allowance for concession adjustments, included in our balance sheets as of June 30 was as follows: 2019—$515; and 2018—$529. Our provision for concession adjustments, included in our results of continuing operations for the years ended June 30, was as follows: 2019—$842; and 2018—$1,242	The largest component of concessions adjustments in our patient accounts receivable for our Healthcare Services and Pharmacy segments relates to accounts for which patients are responsible, which we refer to as patient responsibility accounts. These accounts include both amounts payable by uninsured patients and co-payments and deductibles payable by insured patients. In general, we attempt to collect deductibles, co-payments and self-pay accounts prior to the time of service for non-emergency care. If we do not collect these patient responsibility accounts prior to the delivery of care, the accounts are handled through our billing and collections processes. We attempt to verify each patient's insurance coverage as early as possible before a scheduled non-emergency admission or procedure, including with respect to eligibility, benefits and authorization/pre-certification requirements, in order to notify patients of the estimated amounts for which they will be responsible. We attempt to verify insurance coverage within a reasonable amount of time for all emergency room visits and non-emergency urgent admissions in compliance with the Emergency Medical Treatment and Active Labor Act. In general, we utilize the following steps in collecting accounts receivable: if possible, cash collection of all or a portion of deductibles, co-payments and self-pay accounts prior to or at the time service is provided; billing and follow-up with third party payors; collection calls; utilization of collection agencies; sue to collect if the patient has the means to pay and chooses not to pay; and if collection efforts are unsuccessful, write off the accounts.	A significant increase in our provision for doubtful accounts (as a percentage of revenues) would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and potentially our future access to capital. If net revenues during fiscal year 2019 were changed by 1%, our 2019 after-tax income from continuing operations would change by approximately $456 or diluted earnings per share of $0.06. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate uncollectible patient accounts that are highly uncertain and requires a high degree of judgment. It is impacted by, among other things, changes in regional economic conditions, business office operations, payor mix and trends in private and federal or state governmental healthcare coverage.

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
	Our policy is to write off accounts after all collection efforts have failed, which is typically no longer than 120 days after the date of discharge of the patient or service to the patient or customer. Patient responsibility accounts represent the majority of our write-offs. Our subsidiary hospital retains third-party collection agencies for billing and collection of delinquent accounts; the use of one or more collection agencies promotes competition and improved performance. Generally, we do not write off accounts prior to utilizing the services of a collection agency. Once collection efforts have proven unsuccessful, an account is written off from our patient accounting system against the allowance for doubtful accounts. We determine the adequacy of the allowance for doubtful accounts utilizing a number of analytical tools and benchmarks. No single statistic or measurement alone determines the adequacy of the allowance. We monitor our revenue trends by payor classification on a quarter-by-quarter basis along with the composition of our accounts receivable agings. This review is focused primarily on trends in self-pay revenues, self-pay accounts receivable, co-payment receivables and historic payment patterns. In addition, we analyze other factors such as day's revenue in accounts receivable and we review admissions and charges by physicians, primarily focusing on recently recruited physicians.	

HEALTHCARE SERVICES SEGMENT NET ACCOUNTS RECEIVABLE
JUNE 30, 2019

	Days Outstanding 1							
Payor Class	0 - 30	31 - 60	61 - 90	91 - 120	121 - 150	151 - 180	>180	Total
Medicare..................................	$ 568	$ 21	$ 3	$ 1	$ 0	$ 0	$ 2	$ 595
Medicaid..................................	321	23	5	6	2	1	5	363
Commercial..............................	183	21	22	10	18	10	17	281
Self Pay.....................................	29	20	19	23	13	7	61	172
	$ 1,101	$ 85	$ 49	$ 40	$ 33	$ 18	$ 85	$ 1,411

1 The above table shows, as of June 30, 2019, net Healthcare Services segment accounts receivable aged from patient date of service and are grouped by classification of verified insurance coverage. The receivables are net of contractual allowances and allowance for doubtful accounts. Contractual allowances and the allowance for doubtful accounts are calculated by payor class and are not calculated by the aging of the patient billing date; therefore, these allowances have been allocated within the aging of the various payor classes based upon gross patient receivable amounts.

PHARMACY SEGMENT NET ACCOUNTS RECEIVABLE
JUNE 30, 2019

	Days Outstanding 2					
Payor Class	0 - 30	31 - 60	61 - 90	91 - 120	121 - 150	Total
Medicare	$ 410	$ 40	$ 13	$ 39	$ 71	$ 573
Medicaid...	276	101	42	33	125	577
Private insurance and institutions.....	216	71	27	18	5	337
Private pay	1,013	237	186	158	223	1,817
	$ 1,915	$ 449	$ 268	$ 248	$ 424	$ 3,304

2 The above table shows, as of June 30, 2019, net Pharmacy segment accounts receivable aged from the date of sale or services performed and are grouped by classification of verified payor class. The receivables are net of contractual allowances and concession allowances.

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Revenue recognition / Net Patient Service Revenues		
For our Healthcare Services segment, we recognize revenues in the period in which services are provided. For our Pharmacy segment, we recognize revenues in the period in which services are provided and at the time the customer takes possession of merchandise. Patient receivables primarily consist of amounts due from third-party payors and patients. Amounts we receive for treatment of patients covered by governmental programs, such as Medicare and Medicaid, and other third-party payors, such as HMOs, PPOs and other private insurers, are determined pursuant to contracts or established government rates and are generally less than our established billing rates. Accordingly, our gross revenues and patient receivables are reduced to net amounts receivable pursuant to such contracts or government payment rates through an allowance for contractual discounts. The sources of these revenues were as follows for the year ended June 30, 2019 (as a percentage of total revenues): Medicare—39.9%; Medicaid—30.4%; and Commercial insurance and other sources—13.6%.	Revenues are recorded at estimated amounts due from patients, third-party payors, institutions, and others for healthcare and pharmacy services and goods provided net of contractual discounts pursuant to contract or government payment rates. Estimates for contractual allowances are calculated using computerized and manual processes depending on the type of payor involved. In our hospital, the contractual allowances are calculated by a computerized system based on payment terms for each payor and certain manual estimates are used in calculating contractual allowances based on historical collections from payors that are not significant or have not entered into a contract with us. All contractual adjustments regardless of type of payor or method of calculation are reviewed and compared to actual experience on a periodic basis. Accounts receivable primarily consist of amounts due from third party payors, institutions, and patients. Amounts we receive for the treatment of patients covered by HMOs, PPOs and other private insurers are generally less than our established billing rates. We include contractual allowances as a reduction to revenues in our financial statements based on payor specific identification and payor specific factors for rate increases and denials.	

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
	Governmental payors	**Governmental payors**
	The majority of services performed on Medicare and Medicaid patients are reimbursed at predetermined reimbursement rates. The differences between the established billing rates (i.e., gross charges) and the predetermined reimbursement rates are recorded as contractual discounts and deducted from gross charges. Under this prospective reimbursement system, there is no adjustment or settlement of the difference between the actual cost to provide the service and the predetermined reimbursement rates. Discounts for retrospectively cost-based revenues, which were more prevalent in periods before 2000, are estimated based on historical and current factors and are adjusted in future periods when settlements of filed cost reports are received. Final settlements under all programs are subject to adjustment based on administrative review and audit by third party intermediaries, which can take several years to resolve completely.	Because the laws and regulations governing the Medicare and Medicaid programs are complex and subject to change, the estimates of contractual discounts we record could change by material amounts. Adjustments related to final settlements for revenues retrospectively increased (decreased) our revenues from continuing operations by the following amounts for the years ended June 30: 2019—$(15) and 2018—$135.
	Commercial Insurance	**Commercial Insurance**
	For most managed care plans, contractual allowances estimated at the time of service are adjusted to actual contractual allowances as cash is received and claims are reconciled. We evaluate the following criteria in developing the estimated contractual allowance percentages: historical contractual allowance trends based on actual claims paid by managed care payors; review of contractual allowance information reflecting current contract terms; consideration and analysis of changes in payor mix reimbursement levels; and other issues that may impact contractual allowances.	If our overall estimated contractual discount percentage on all of our commercial revenues during 2019 were changed by 1%, our 2019 after-tax income from continuing operations would change by approximately $62. This is only one example of reasonably possible sensitivity scenarios. The process of determining the allowance requires us to estimate the amount expected to be received and requires a high degree of judgment. It is impacted by changes in managed care contracts and other related factors. A significant increase in our estimate of contractual discounts would lower our earnings. This would adversely affect our results of operations, financial condition, liquidity and future access to capital.

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	**Assumption / Approach Used (dollar amounts in thousands, except per share)**	**Sensitivity Analysis (dollar amounts in thousands, except per share)**
Intangible assets and accounting for business combinations		
Our intangible assets by business segment included in our consolidated balance sheets as of June 30 for the following years was as follows:	In accordance with FASB Accounting Standards Codification 350-10, “Intangibles—Goodwill and Other,” (“ASC 350-10”) goodwill and intangible assets with indefinite lives are reviewed by us at least annually for impairment. For purposes of these analyses, the estimate of fair value is based on the income approach, which estimates the fair value based on future discounted cash flows. The estimate of future discounted cash flows is based on assumptions and projections that are believed to be currently reasonable and supportable. If it is determined the carrying value of goodwill or other intangible assets to be impaired, then the carrying value is reduced. The purchase price of acquisitions is allocated to the assets acquired and liabilities assumed based upon their respective fair values and are subject to change during the twelve month period subsequent to the acquisition date. We engage independent third-party valuation firms to assist us in determining the fair values of assets acquired and liabilities assumed at the time of acquisition. Such valuations require us to make significant estimates and assumption, including projections of future events and operating performance.	

	2019	2018
Pharmacy		
Trade name	$ 1,180	$ 1,180
Customer relationships	1,089	1,089
Medicare License	623	623
	2,892	2,892
Accumulated amortization	(1,539)	(1,422)
Total	$ 1,353	$ 1,470

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
	Fair value estimates are derived from independent appraisals, established market values of comparable assets, or internal calculations of estimated future net cash flows. Our estimate of future cash flows is based on assumptions and projections we believe to be currently reasonable and supportable. Our assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.	
Professional and general liability claims		
We are subject to potential medical malpractice lawsuits and other claims as part of providing healthcare and pharmacy related services. To mitigate a portion of this risk, we have maintained insurance for individual malpractice claims exceeding a self-insured retention amount. Our self-insurance retention amount was $1,000 on individual malpractice claims for each contract year commencing March 1, 2011 through February 29, 2016 and was reduced to $750 from March 1, 2016 to now. Each year, we obtain quotes from various malpractice insurers with respect to the cost of obtaining medical malpractice insurance coverage. We compare these quotes to our most recent actuarially determined estimates of losses at various self-insured retention levels. Accordingly, changes in insurance costs affect the self-insurance retention level we choose each year. As insurance costs increase, we may accept a higher level of risk in self-insured retention levels.	The reserve for professional and general liability claims is based upon independent actuarial calculations, which consider historical claims data, demographic considerations, severity factors and other actuarial assumptions in the determination of reserve estimates. The reserve for professional and general liability claims reflects the current estimate of all outstanding losses, including incurred but not reported losses, based upon actuarial calculations as of the balance sheet date. The loss estimates included in the actuarial calculations may change in the future based upon updated facts and circumstances. We revise our reserve estimation process by obtaining independent actuarial calculations quarterly.	Actuarial calculations include a large number of variables that may significantly impact the estimate of ultimate losses recorded during a reporting period. In determining loss estimates, professional judgment is used by each actuary by selecting factors that are considered appropriate by the actuary for our specific circumstances. Changes in assumptions used by our independent actuary with respect to demographics and geography, Industry trends, development patterns and judgmental selection of other factors may impact our recorded reserve levels and our results of operations. Changes in our initial estimates of professional and general liability claims are non-cash charges and accordingly, there would be no material impact currently on our liquidity or capital resources.

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
The reserve for professional and general liability claims included in our consolidated balance sheets as of June 30 was as follows: 2019—$920; and 2018—$1,258 The total increases for professional and general liability coverage, included in our consolidated results of operations for the years ended June 30, was as follows: 2019—$351; and 2018—$267.	Our estimated reserve for professional and general liability claims will be significantly affected if current and future claims differ from historical trends. While we monitor reported claims closely and consider potential outcomes as estimated by our independent actuaries when determining our professional and general liability reserves, the complexity of the claims, the extended period of time to settle the claims and the wide range of potential outcomes complicates the estimation process. In addition, certain states, including Georgia, have passed varying forms of tort reform which attempt to limit the number and types of claims and the amount of some medical malpractice awards. If enacted limitations remain in place or if similar laws are passed in the states where our other medical facilities are located, our loss estimates could decrease. Conversely, liberalization of the number and type of claims and damage awards permitted under any such law applicable to our operations could cause our loss estimates to increase.	

Balance Sheet or Statement of Operations and Comprehensive Earnings and Loss Caption/Nature of Critical Estimate Item (dollar amounts in thousands, except per share)	Assumption / Approach Used (dollar amounts in thousands, except per share)	Sensitivity Analysis (dollar amounts in thousands, except per share)
Accounting for income taxes		
Deferred tax assets generally represent items that will result in a tax deduction in future years for which we have already recorded the tax benefit in our Statement of Operations and Comprehensive Earnings and Loss. We assess the likelihood that deferred tax assets will be recovered from future taxable income. To the extent we believe that recovery is not probable, a valuation allowance is established. To the extent we establish a valuation allowance or increase this allowance, we must include an expense as part of the income tax provision in our results of operations. Our net deferred tax asset balance (net of valuation allowance) in our consolidated balance sheets as of June 30 for the following years was as follows: 2019—$0; and 2018—$0. Our valuation allowances for deferred tax assets in our consolidated balance sheets as of June 30 for the following years were as follows: 2019—$8,625; and 2018—$8,373. In addition, significant judgment is required in determining and assessing the impact of certain tax-related contingencies. We establish accruals when, despite our belief that our tax return positions are fully supportable, it is probable that we have incurred a loss related to tax contingencies and the loss or range of loss can be reasonably estimated. We adjust the accruals related to tax contingencies as part of our provision for income taxes in our results of operations based upon changing facts and circumstances, such as the progress of a tax audit, development of industry related examination issues, as well as legislative, regulatory or judicial developments. A number of years may elapse before a particular matter, for which we have established an accrual, is audited and resolved.	The first step in determining the deferred tax asset valuation allowance is identifying reporting jurisdictions where we have a history of tax and operating losses or are projected to have losses in future periods as a result of changes in operational performance. We then determine if a valuation allowance should be established against the deferred tax assets for that reporting jurisdiction. The second step is to determine the amount of the valuation allowance. We will generally establish a valuation allowance equal to the net deferred tax asset (deferred tax assets less deferred tax liabilities) related to the jurisdiction identified in the first step of the analysis. In certain cases, we may not reduce the valuation allowance by the amount of the deferred tax liabilities depending on the nature and timing of future taxable income attributable to deferred tax liabilities. In assessing tax contingencies, we identify tax issues that we believe may be challenged upon examination by the taxing authorities. We also assess the likelihood of sustaining tax benefits associated with tax planning strategies and reduce tax benefits based on management's judgment regarding such likelihood. We compute the tax on each contingency. We then determine the amount of loss, or reduction in tax benefits based upon the foregoing and reflects such amount as a component of the provision for income taxes in the reporting period. During each reporting period, we assess the facts and circumstances related to recorded tax contingencies. If tax contingencies are no longer deemed probable based upon new facts and circumstances, the contingency is reflected as a reduction of the provision for income taxes in the current period.	Our deferred tax assets were $8,625 at June 30, 2019, excluding the impact of valuation allowances. At June 30, 2019, the Company evaluated the need for a valuation allowance against our deferred tax assets and determined that it was more likely than not that none of our deferred tax assets would be realized. As a result, in accordance with ASC 740, we recognized a total valuation allowance of $8,625 against the deferred tax asset so that the net tax deferred asset was $0 at June 30, 2019. We conducted our evaluation by considering available positive and negative evidence to determine our ability to realize our deferred tax assets. In our evaluation, we gave more significant weight to evidence that was objective in nature as compared to subjective evidence. Also, more significant weight was given to evidence we judged directly related to our current financial performance as compared to less current evidence and future plans. The IRS may propose adjustments for items we have failed to identify as tax contingencies. If the IRS were to propose and sustain assessments equal to 10% of our taxable income for 2019, we would incur approximately $0 of additional tax expense for 2019 plus applicable penalties and interest.

Financial Summary

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

	2019	2018
Net Revenues—Healthcare Services	$ 15,453	$ 15,745
Net Revenues—Pharmacy	30,165	29,464
Total Net Revenues	45,618	45,209
Costs and expenses	(48,000)	(46,342)
Electronic health records incentives	68	21
Operating Loss	(2,314)	(1,112)
Gain on economics damages claim—net	22	944
Interest Expense	(241)	(359)
Loss on extinguishment of debt—net	0	(238)
Gain (Loss) on sale of assets	455	194
Loss from continuing operations before income taxes	$ (2,078)	$ (571)
Healthcare Services segment:		
Hospital and Nursing Home Admissions	487	518
Hospital and Nursing Home Patient Days	26,780	25,432

Results of Operations

Our net revenues are from our two business segments, Healthcare Services and Pharmacy. The Company's net revenues by payor were as follows for the years ended June 30, 2019 and 2018:

	2019	2018
Medicare	$ 18,183	$ 18,446
Medicaid	13,871	12,636
Retail and Institutional Pharmacy	6,649	6,505
Managed Care & Other Insurance	6,220	6,922
Self-pay	505	502
Rent	63	68
Other	127	130
Total Net Revenues	$ 45,618	$ 45,209

Healthcare Services net revenues in the current year is composed of one hospital, one nursing home, a subsidiary which provides information technology services to outside customers and SunLink subsidiaries, a leased medical office building and unimproved land. Healthcare Services net revenues decreased $292 or 1.8% in the year ended June 30, 2019 compared to the year ended June 30, 2018. The decrease in net revenues for fiscal 2019 resulted from decreased IT services net revenues that were only partially offset by increased nursing home net revenues. Nursing home resident days increased 8% in the fiscal year ended June 30, 2019 compared to the prior year. Net revenues from continuing operations decreased $15 for the year ended June 30, 2019 and increased $135 for the year ended June 30, 2018 from the settlement of prior year Medicare and Medicaid cost reports.

Pharmacy Segment net revenues for the year ended June 30, 2019 of $30,165 increased 2.4% from the prior year due to increased net revenues from Institutional Pharmacy and DME. The Institutional Pharmacy revenues increased 7.3% due to a 14.8% increase in scripts filled this year. DME revenues increased 2.2% due to a 1.0% increase in sales orders and elimination of certain products which we believe generate lower net operating profit. The Retail Pharmacy net revenues decreased 7.0% this fiscal year, primarily due to the sale of a retail pharmacy operation in early January 2018. On a same store comparison, Retail Pharmacy net revenues increased 2.7%.

Costs and expenses, including depreciation and amortization, were $48,000 and $46,342 for the fiscal years ended June 30, 2019 and 2018, respectively. Costs and expenses as a percentage of net revenues were:

	2019	2018
Cost of goods sold	41.5%	41.0%
Salaries, wages and benefits	42.1%	41.1%
Supplies	2.7%	2.7%
Purchased services	5.5%	4.8%
Other operating expenses	8.5%	8.1%
Rent and lease expense	1.3%	1.4%
Impairments	0.3%	0.0%
Depreciation and amortization expense	3.3%	3.4%

Cost of goods sold as a percent of net revenues increased 0.5% in the fiscal year ended June 30, 2019 compared to the prior fiscal year due to a 43.0% increase of sales of infusion therapy and injectable drugs in the current year. These products have a higher cost of goods sold as a percent of net revenues. Salaries, wages and benefits expense as a percent of net revenues increased 1.0% this year compared to the prior fiscal year due to increased employee medical claims expense. Purchased services expenses as a percent of net revenues increased 0.7% this year compared to the prior fiscal year due to the addition of a new contracted service line at a hospital. Other operating expense increased 0.4% in the fiscal year ended June 30, 2019 compared to the prior fiscal year due to higher legal expenses.

Operating Profit (Loss)

Operating losses were $2,314 for the year ended June 30, 2019 and $1,112 for the year ended June 30, 2018. The increased operating loss in the year ended June 30, 2019 compared to prior fiscal year resulted from the increased operating loss of the Healthcare Services segment.

Gain on economic damages claim

The Pharmacy Segment subsidiary asserted claims for economic damages in connection with the Deepwater Horizon Settlement Program related to the event, which occurred in 2010. In January 2018, these claims were settled and payments of approximately $944 (net of costs and attorneys' fees) were received. In May 2019, an additional payment of $22 was received. The net settlements are recognized as a gain in the years ended June 30, 2019 and 2018, respectively.

Interest Expense-net

Interest expense was $241 and $359 for the years ended June 30, 2019 and 2018, respectively. The decrease in interest expense for the year ended June 30, 2019 was due to lower outstanding debt.

Gain on Sale of Assets

On October 11, 2018, the Company sold a vacant medical office building and approximately two adjacent acres of undeveloped land. After expenses, the Company received net proceeds from the sale of $935, which was retained for working capital and general corporate purposes. The pre-tax gain on the sale of property was $452 and is included in the results for the year ended June 30, 2019.

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

Income Taxes

We recorded income tax benefit of $82 ($113 federal tax benefit and $31 state tax expense) for the year ended June 30, 2019 compared to $345 ($296 federal tax benefit and $49 state tax benefit) for the year ended June 30, 2018.

In accordance with the Financial Accounting Standards Board Accounting Standards Codification (‘ASC”) 740, we evaluate our deferred taxes quarterly to determine if adjustments to our valuation allowance are required based on the consideration of available positive and negative evidence using a “more likely than not” standard with respect to whether deferred tax assets will be realized. Our evaluation considers, among other factors, our historical operating results, our expectation of future results of operations, the duration of applicable statuary carryforward periods and conditions of the healthcare industry. The ultimate realization of our deferred tax assets depends primarily on our ability to generate future taxable income during the periods in which the related temporary differences in the financial basis and the tax basis of the assets become deductible. The value of our deferred tax assets will depend on applicable income tax rates.

The Tax Cuts and Jobs Act (“TCJA”) was enacted on December 22, 2017. Under ASC 740, the impact of changes in tax law must be recorded in the financial statements in the reporting period that included the date of enactment. In addition, in conjunction with the TCJA, on December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118, Income Tax Accounting Implications of the Tax Cuts and Jobs Act (SAB 118), which provides guidance on accounting for the tax effects of the TCJA. SAB 118 allows for recording certain effects of the TCJA as “provisional” during a one-year measurement period, which for the Company ended in the second quarter of fiscal 2019.

At June 30, 2019, consistent with the above process, we evaluated the need for a valuation against our deferred tax assets and determined that it was more likely than not that none of our deferred tax assets would be realized. As a result, in accordance with ASC 740, we recognized a valuation allowance of $8,625 against the deferred tax asset so that there is no net long-term deferred income tax asset or liability at June 30, 2019. We conducted our evaluation by considering available positive and negative evidence to determine our ability to realize our deferred tax assets. In our evaluation, we gave more significant weight to evidence that was objective in nature as compared to subjective evidence. In addition, more significant weight was given to evidence that directly related to our current financial performance as compared to less current evidence and future plans.

The principal negative evidence that led us to determine at June 30, 2019 that all the deferred tax assets should have full valuation allowances was the three-year cumulative pre-tax loss from continuing operations as well as the underlying negative business conditions for rural healthcare businesses in which our Healthcare Services Segment businesses operate.

For Federal income tax purposes, at June 30, 2019, the Company had approximately $16,700 of estimated net operating loss carry-forwards available for use in future years subject to the limitations of the provisions of Internal Revenue Code Section 382. These net operating loss carryforwards expire primarily in fiscal 2023 through fiscal 2038; however, with the enactment of the TCJA on December 22, 2017, federal net operating loss carryforwards generated in taxable years beginning after December 31, 2017 now have no expiration date. The Company’s returns for the periods prior to the fiscal year ended June 30, 2016 are no longer subject to potential federal and state income tax examination

We recorded a discrete net tax benefit of $0 during the year ended June 30, 2018 related to provisional amounts under SAB 118 for the remeasurement of U.S. deferred tax assets and liabilities due to the Federal tax rate reduction to 21%. No net tax benefit was recorded due to the Company’s full valuation allowance position. The $296 of tax benefit recorded for the year ended June 30, 2018 was due to the release of the valuation allowance on the Company’s Alternative Minimum Tax (“AMT”) Credit, which became refundable under the TCJA. The final amount of AMT Credit valuation allowance release at June 30, 2018 was $305 due to adjustments made from the final June 30, 2017 tax return filing during the fourth quarter ended fiscal 2018. We also recorded an additional $40 of tax benefit at June 30, 2018 unrelated to the remeasurement of U. S. deferred tax assets and liabilities. No changes were recorded to this provisional estimate during the year ended June 30, 2019. Pursuant to the requirements of SAB 118 as discussed above the Company has completed its accounting for the TCJA for the second quarter ended fiscal 2019.

Discontinued Operations

Earnings from discontinued operations net of income taxes were $242 for the year ended June 30, 2019, and a loss from discontinued operations net of income taxes was $1,367 for the year ended June 30, 2018. The results of all the businesses in discontinued operations are presented below:

Parkside Nursing Home — On March 17, 2019, a subsidiary of the Company sold its Parkside Ellijay Nursing Home (“Parkside”) and related real estate for $7,300 subject to adjustment for the book value of certain assets and liabilities on the sale date. The pre-tax gain on the sale is $2,136, which is also subject to adjustment for the book value of certain assets and liabilities on the sale date. The net proceeds of the sale were retained for working capital and general corporate purposes.

Sold Hospitals – Subsidiaries of the Company have sold substantially all of the assets of four hospitals ("Other Sold Hospitals") during the period July 2, 2012 to August 19, 2016. The income (loss) before income taxes of the Other Sold Hospitals results primarily from the effects of prior year Medicare and Medicaid cost report settlements and retained professional liability claims expenses.

Life Sciences and Engineering Segment —SunLink retained a defined benefit retirement plan which covered substantially all of the employees of this segment when the segment was sold in fiscal 1998. Effective February 28, 1997, the plan was amended to freeze participant benefits and close the plan to new participants. Pension expense and related tax benefit or expense is reflected in the results of operations for this segment for the fiscal years ended June 30, 2019 and 2018.

Discontinued Operations—Summary Statement of Earnings Information

	2019	2018
Net Revenues:		
Parkside	$ 5,574	$ 6,960
Sold Hospitals	(581)	82
	$ 4,993	$ 7,042
Loss Before Income Taxes:		
Parkside	$ (756)	$ (1,006)
Sold Hospitals	(919)	(89)
Life sciences and engineering	(137)	(159)
Loss before income taxes	(1,812)	(1,254)
Gain (Loss) on Sale:		
Parkside	2,136	0
Sold Hospitals	0	(113)
Gain (Loss) on Sale	2,136	(113)
Income tax expense	82	0
Earnings (Loss) from discontinued operations	$ 242	$ (1,367)

Net Loss — Net loss for the year ended June 30, 2019 was $1,754 (a loss of $0.25 per fully diluted share) compared to the net loss for the year ended June 30, 2018 of $1,593 (a loss of $0.19 per fully diluted share).

Liquidity and Capital Resources

Overview

Our primary source of liquidity is unrestricted cash on hand, which was $7,742 at June 30, 2019. Currently, the Company's ability to raise capital (debt or equity) in the public or private markets on what it considers acceptable terms is uncertain. We nevertheless periodically seek options to obtain financing for the liquidity needs of the Company or individual subsidiaries. The Company and its subsidiaries currently are funding working capital needs primarily from cash on hand and from the sale of assets.

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

Trace RDA Loan— Southern Health Corporation of Houston, Inc. ("Trace") a wholly owned subsidiary of the Company, closed on a $9,975 Mortgage Loan Agreement ("Trace RDA Loan") with a bank, dated as of July 5, 2012. The Trace RDA Loan has a term of 15 years with level monthly payments of principal and interest until repaid. On December 26, 2017, the Fifth Amendment to Loan Agreement, Modification of Note and Waiver ("Modification") was entered into by Trace and the bank. Under the Modification, Trace made a $3,548 prepayment on the Trace RDA Loan. The monthly principal and interest payments on the Trace RDA Loan were reduced, the interest rate was reduced to the prime rate (as published in the Wall Street Journal) plus 1% with a floor of 5.5%, (6.5% at June 30, 2019) and certain loan covenants were modified. The Trace RDA Loan is collateralized by real estate and equipment of Trace in Houston, MS, and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program.

The Trace RDA Loan subsidiary contains various terms and conditions, including financial restrictions and limitations, and affirmative and negative covenants. The loan is guaranteed by SunLink. At June 30, 2019, Trace was not in compliance with the debt service coverage, fixed charge coverage and funded debt to EBITDA ratios. The Company is discussing with the lender a waiver of this non-compliance but a waiver of non-compliance has not been received as of the date of the filing of this report. No event of default has been declared by the lender as of the date of the filing of this report nor is such a declaration currently anticipated. Indebtedness of $2,535, net of unamortized debt costs, as of June 30, 2019, is presented in current liabilities in the consolidated balance sheet as a result of the financial covenant non-compliance at that date. The ability of Trace to continue to make the required debt service payments under the Trace RDA Loan depends on, among other things, its ability to generate sufficient cash, including from operating activities and asset sales. If Trace is unable to generate sufficient cash to meet debt service payments on the Trace RDA Loan, including in the event the lender were to declare an event of default and accelerate the maturity of the indebtedness, such failure could have material adverse effects on the Company. The Trace RDA Loan is guaranteed by the Company and one subsidiary.

Contractual Obligations, Commitments and Contingencies

Contractual obligations related to long-term debt, non-cancelable operating leases and interest on outstanding debt from continuing operations at June 30, 2019 is shown in the following table. The interest on variable interest debt is calculated at the interest rate in effect at June 30, 2019.

Payments due in:	Long-Term Debt	Operating Leases	Interest on Long-Term Debt
1 year	$ 3,031	$ 592	$ 186
2 years	34	330	8
3 years	36	129	5
4 years	39	3	3
5 years	18	0	0
More than 5 years	0	0	0
	$ 3,158	$ 1,054	$ 202

Long-term Debt —At June 30, 2019, we had outstanding long-term debt of $3,158, which was composed of the Trace RDA Loan of $2,999 and capital lease debt of $159.

Recent Accounting Pronouncements

In January 2017, the Financial Accounting Standards Board (“FASB”) issued Accounting Standards Update (“ASU”) 2017-04, which simplifies the accounting for goodwill impairment by eliminating step two from the goodwill impairment test. Instead of a two-step impairment model, if the carrying amount of a reporting unit exceeds its fair value as determined in step one of the impairment test, an impairment loss is measured at the amount equal to that excess, limited to the total amount of goodwill allocated to that reporting unit. This ASU is effective for any interim or annual impairment tests for fiscal years beginning after December 15, 2019, with early adoption permitted. The Company is evaluating what impact it will have on its consolidated financial position and results of operations.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost will be reported in the same Statement of Operations and Comprehensive Earnings and Loss line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost will be presented separately in a line item outside of operating income. This ASU was effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on July 1, 2018. The Company has only one defined benefit plan for pension which is frozen for new participants and the cost of the plan is reported in discontinued operations. Since the changes required in this new ASU only change the income statement classification of the components of net periodic benefit cost, no changes to the presentation of income from continuing operations nor net income was required.

In May 2014, the FASB issued ASU 2014-9, “Revenue from Contracts with Customers”, along with subsequent amendments, updates and an extension of the effective date (collectively, the “New Revenue Standard” or “ASC 606”), which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance. This Standard was adopted July 1, 2018. See Note 5 Revenue Recognition and Accounts Receivable for further discussion.

In February 2018, the FASB issued Accounting Standards Update 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* (“ASU 2018-02”). This ASU was effective for fiscal years beginning after December 15, 2018. The Company early adopted this ASU as of July 1, 2018 and applied its provisions during the fiscal year ended June 30, 2019, instead of retrospectively at the date of adoption. In implementing the provisions of the Tax Cuts and Jobs Act of 2017 (the “Tax Act”), the remeasurement of our deferred tax assets and liabilities was recorded as a component of our provision for income taxes. For deferred tax amounts that were originally recorded through accumulated other comprehensive income (“AOCI”), the remeasurement of deferred tax assets and liabilities through the provision for income taxes resulted in these amounts becoming “stranded” in AOCI. ASU 2018-02 permits companies to reclassify the stranded tax amounts recorded in AOCI to retained earnings, and we reclassified $69 of stranded tax effects from AOCI to retained earnings effective June 30, 2019.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a corresponding lease liability. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company is required to adopt this ASU on July 1, 2019. In July 2018, the FASB issued ASU 2018-11, which provides entities relief from the transition requirements in ASU 2016-02 by allowing them to elect not to recast prior comparative periods. The Company plans to elect this method of transition upon adoption of this ASU. Because of the few number of leases the Company utilizes to support its operations, the adoption of this ASU is not expected to have a significant impact on the Company’s consolidated financial position and results of operations. Management is currently evaluating the extent of this anticipated impact on the Company’s consolidated financial position and results of operations, and the quantitative and qualitative factors that will impact the Company as part of the adoption of this ASU, as well as any changes to its leasing strategy that may occur because of the changes for the accounting and recognition of leases.

Related Party Transactions

A director of the Company is a member of a law firm which provides services to SunLink. The Company has expensed an aggregate of $306 and $229 to the law firm in the fiscal years ended June 30, 2019 and 2018, respectively. Included in the Company’s consolidated balance sheets at June 30, 2019 and 2018 is $47 and $10 of amounts payable to the law firm.

On June 5, 2018, the Company purchased 70,000 common shares from a director of the Company at a price equal to the closing price on that date of the Company’s common shares on the NYSE American Exchange.

Subsequent Events

Sale of property — On September 9, 2019, the Company sold approximately 11.4 acres of undeveloped land. After expenses, the Company received net proceeds from the sale of $348, which is being retained for working capital needs and general corporate purposes. The pre-tax gain on the sale is approximately $100, which will be included in the results for the fiscal quarter ended September 30, 2019.

Stock option issuance — On September 9, 2019, a total of options for 50,000 shares were issued by the Company to non-employee directors (10,000 to each) at a price of $1.38 per share from the 2011 Director Stock Option Plan.

Stock option forfeiture — On September 9, 2019, 165,000 unexpired stock options issued under the 2005 Equity Incentive Plan with exercise prices $1.79 and $2.09 were forfeited by two employees.

Inflation

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

Item 8. Financial Statements and Supplementary Data.

Index to Financial Statements and Supplementary Data

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

As required by Rule 13a-15 under the Securities Exchange Act of 1934 (the "Exchange Act "), as of the end of the period covered by this report, we carried out an evaluation of the effectiveness of the design and operation of our Company's disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e)) under the Exchange Act. Under the direction of our principal executive officer and principal financial officer, we evaluated our disclosure controls and procedures and internal control over financial reporting and concluded that our disclosure controls and procedures were effective as of June 30, 2019.

Disclosure controls and procedures and other procedures are designed to ensure that information required to be disclosed in our reports or submitted under the Exchange Act, such as this Annual Report on Form 10-K, is recorded, processed, summarized and reported within the time period specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed in our reports filed under the Exchange Act is accumulated and communicated to management, including our principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure.

Based on an evaluation of the effectiveness of disclosure controls and procedures performed in connection with this Annual Report on Form 10-K, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures were effective as of June 30, 2019.

Management's Responsibility for Financial Statements

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

The Audit Committee of the Board of Directors, which is composed solely of independent directors, meets regularly with the Company's independent registered public accounting firm and representatives of management to review accounting, financial reporting, internal control and audit matters, as well as the nature and extent of the audit effort. The Audit Committee is responsible for the engagement of the independent registered public accounting firm. The independent registered public accounting firm has free access to the Audit Committee.

Management's Report on Internal Control Over Financial Reporting

The management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. Our internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of our financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with U.S. generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Management assessed the effectiveness of the Company's internal control over financial reporting as of June 30, 2019. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control—Integrated Framework* (2013). Based on our assessment we concluded that, as of June 30, 2019, the Company's internal control over financial reporting was effective based on those criteria.

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

Changes in Internal Control over Financial Reporting

During the last fiscal quarter ended June 30, 2019, there has been no significant change in the Company's internal control over financial reporting that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

PART III

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholders Matters.

Securities Authorized for Issuance under Equity Compensation Plans

Incorporated by reference from the registrant's definitive Proxy Statement to be filed under Regulation 14A in connection with the Annual Meeting of Shareholders of SunLink Health Systems, Inc. scheduled to be held on November 11, 2019.

PART IV

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

(a) (1) Financial Statements

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

Report of Independent Registered Public Accounting Firm.

Consolidated Balance Sheets—June 30, 2019 and 2018.

Consolidated Statements of Operations and Comprehensive Earnings and Loss—For the Years Ended June 30, 2019 and 2018.

Consolidated Statements of Shareholders' Equity—For the Years Ended June 30, 2019 and 2018.

Consolidated Statements of Cash Flows—For the Years Ended June 30, 2019 and 2018.

Notes to Consolidated Financial Statements—For the Years Ended June 30, 2019 and 2018.

(a) (2) Financial Statement Schedules

Report of Independent Registered Public Accounting Firm	At page 56 of this Report
Schedule II Valuation and Qualifying Accounts	At page 57 of this Report

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

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

(b) Exhibits

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

3.1	Amended Articles of Incorporation of SunLink Health Systems, Inc. (incorporated by reference from Exhibit 3.1 of the Company's Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.1a	Amended Articles of Incorporation of KRUG International Corp. (incorporated by reference to Exhibit 3.1 of the Corporation's Report on Form 10-K405 for the year ended March 31, 1998). (Commission File No. 98649171)
3.1b	Amended Articles of Incorporation of SunLink Health Systems, Inc. (incorporated by reference from Exhibit 3.2 of the Company's Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.1c	Certificate of Amendment to Amend Article Fourth of the Amended Articles of Incorporation of SunLink Health Systems, Inc. dated February 13, 2004 (incorporated by reference from Exhibit 3.1 of the Company's Report on Form 10-Q for the quarter ended December 31, 2003). (Commission File No. 04610446)
3.1d	Certificate of Amendment to Amend and Restate Article Fourth of the Company's Amended Articles of Incorporation (incorporated by reference from Exhibit 3.1d of the Company's Report on Form 8-K filed September 29, 2016). (Commission File No. 161910046)
3.2	Code of Regulations of SunLink Health Systems, Inc., as amended (incorporated by reference from Exhibit 3.1 of the Company's Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.3	Certificate of Amendment to Amend Article Fourth of the Amended Articles of Incorporation of SunLink Health Systems, Inc. dated February 13, 2004 (incorporated by reference from Exhibit 3.1 of the Company's Report on Form 10-Q for the quarter ended December 31, 2003). (Commission File No. 04610446)

4.1 Shareholder Rights Agreement dated as of February 10, 2014, between SunLink Health Systems, Inc. and American Stock Transfer & Trust Company, LLC, as Rights Agent (incorporated by reference from Exhibit 4.1 of the Company's Report on Form 8-K filed February 27, 2014). (Commission File No. 14647348)

4.2 Tax Benefits Preservation Rights Plan between SunLink Health Systems, Inc. and American Stock Transfer & Trust, LLC, as Rights Agent dated as of September 29, 2016. (incorporated by reference from Exhibit 4.2 of the Company's Report on Form 8-K filed September 29, 2016). (Commission File No. 161910046)

4.3 Definition of Registrant's Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934.^

10.1* Employment Letter, dated April 30, 2001, by and between SunLink Health Systems, Inc. and Mark Stockslager (incorporated by reference from Exhibit 10.29 of the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2005). (Commission File No. 051197210)

10.2* Amended and Restated Employment Agreement, dated July 1, 2005, between Robert M. Thornton, Jr. and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.1 of the Company's Report on Form 8-K filed December 23, 2005). (Commission File No. 051285094)

10.3* 2005 Equity Incentive Plan (incorporated by reference from Exhibit 99.1 of the Company's Registration Statement on Form S-8 filed September 20, 2006). (Commission File No. 061100389)

10.4 Agreement of Understanding, dated June 28, 2007, between Christopher H. B. Mills and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.2 of the Company's Report on Form 8-K filed July 16, 2007). (Commission File No. 07982325)

10.5* Employment letter dated September 23, 2010 with an effective date of September 30, 2010, by and between SunLink ScriptsRx, LLC and Byron D. Finn (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)

10.6 Mortgage Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676)

10.7 Working Capital Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676)

10.8 Amendment and Waiver to Mortgage Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205)

10.9 Amendment and Waiver to Working Capital Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205)

10.10 Second Amendment and Waiver to Mortgage Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753)

10.11 Second Amendment and Waiver to Working Capital Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753)

10.12 Third Amendment and Waiver to Mortgage Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2014). (Commission File No. 1141123931)

10.13 Third Amendment and Waiver to Working Capital Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2014). (Commission File No. 1141123931)

10.14* 2011 Director Stock Option Plan (incorporated by reference from Appendix A to the Company's Schedule 14A Definitive Proxy Statement filed September 29, 2011) (Commission File No. 111115265).

10.15 Fourth Amendment effective July 5, 2015, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2015). (Commission File No. 151125045)

10.16 Limited Waiver to Mortgage Loan Agreement as of March 31, 2016 among Southern Health Corporation of Houston, Inc. Crown Healthcare Investments, LLC SunLink Health Systems, Inc. and Bank SNB. (Incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016). (Commission File No. 161646127)

10.17 Limited Waiver to Working Capital Loan Agreement as of March 31, 2016 among Southern Health Corporation of Houston, Inc. Crown Healthcare Investments, LLC SunLink Health Systems, Inc. and Bank SNB. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016). (Commission File No. 161646127)

10.18 Limited Waiver dated August 10, 2016 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB. (incorporated by reference from the Company's Current Report on Form 8-K filed August 25, 2016) (Commission File No. 161851572)

10.19 Fourth Amendment to Loan Agreement and Waiver dated January 6, 2017 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB, National Association (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended December 31, 2016). (Commission File No. 17609813)

10.20 Fifth Amendment to Loan Agreement and Waiver dated December 26, 2017 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB, National Association (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended December 31, 2017). (Commission File No. 18613104)

10.21 Asset Purchase Agreement by and between Southern Health Corporation of Ellijay, Inc., Parkside Property Company LLC, Parkside Lessor Company LLC and Parkside Operating Company LLC, dated February 28, 2019 (incorporated by reference from the Company's Report on Form 8-K filed on March 4, 2019). (Commission File No. 19652705)

21.1 List of Subsidiaries ^

23.1 Consent of Cherry Bekaert LLP ^

31.1 Chief Executive Officer's Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934. ^

31.2 Chief Financial Officer's Certification Pursuant to Rule 13a-14(a) of the Securities Exchange Act of 1934. ^

32.1 Chief Executive Officer's Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. ^

32.2 Chief Financial Officer's Certification Pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. ^

101 The following materials from the Company's Year End Report on Form 10-K for the fiscal year ended June 30, 2019, formatted in eXtensible Business Reporting Language ("XBRL"): (i) Consolidated Balance Sheets as of June 30, 2019 and June 30, 2018, (ii) Consolidated Statements of Operations and Comprehensive Earnings and Loss for the fiscal years ended June 30, 2019 and 2018, (iii) Consolidated Statements of Shareholders' Equity for the fiscal years ended June 30, 2019 and 2018 (iv) Consolidated Statements of Cash Flows for the fiscal years ended June 30, 2019 and 2018 and (v) Notes to Consolidated Financial Statements.

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

INDEX TO EXHIBITS

3.1	Amended Articles of Incorporation of SunLink Health Systems, Inc. (incorporated by reference from Exhibit 3.1 of the Company’s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.1a	Amended Articles of Incorporation of KRUG International Corp. (incorporated by reference to Exhibit 3.1 of the Corporation’s Report on Form 10-K405 for the year ended March 31, 1998). (Commission File No. 98649171)
3.1b	Amended Articles of Incorporation of SunLink Health Systems, Inc. (incorporated by reference from Exhibit 3.2 of the Company’s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.1c	Certificate of Amendment to Amend Article Fourth of the Amended Articles of Incorporation of SunLink Health Systems, Inc. dated February 13, 2004 (incorporated by reference from Exhibit 3.1 of the Company’s Report on Form 10-Q for the quarter ended December 31, 2003). (Commission File No. 04610446)
3.1d	Certificate of Amendment to Amend and Restate Article Fourth of the Company’s Amended Articles of Incorporation (incorporated by reference from Exhibit 3.1d of the Company’s Report on Form 8-K filed September 29, 2016). (Commission File No. 161910046)
3.2	Code of Regulations of SunLink Health Systems, Inc., as amended (incorporated by reference from Exhibit 3.1 of the Company’s Report on Form 10-Q for the quarter ended September 30, 2001). (Commission File No. 1789180)
3.3	Certificate of Amendment to Amend Article Fourth of the Amended Articles of Incorporation of SunLink Health Systems, Inc. dated February 13, 2004 (incorporated by reference from Exhibit 3.1 of the Company’s Report on Form 10-Q for the quarter ended December 31, 2003). (Commission File No. 04610446)
4.1	Shareholder Rights Agreement dated as of February 10, 2014, between SunLink Health Systems, Inc. and American Stock Transfer & Trust Company, LLC, as Rights Agent (incorporated by reference from Exhibit 4.1 of the Company’s Report on Form 8-K filed February 27, 2014). (Commission File No. 14647348)
4.2	Tax Benefits Preservation Rights Plan between SunLink Health Systems, Inc. and American Stock Transfer & Trust, LLC, as Rights Agent dated as of September 29, 2016. (incorporated by reference from Exhibit 4.2 of the Company’s Report on Form 8-K filed September 29, 2016). (Commission File No. 161910046)
4.3	Definition of Registrant’s Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934.^
10.1*	Employment Letter, dated April 30, 2001, by and between SunLink Health Systems, Inc. and Mark Stockslager (incorporated by reference from Exhibit 10.29 of the Company’s Quarterly Report Form 10-Q for the quarter ended September 30, 2005). (Commission File No. 051197210)
10.2*	Amended and Restated Employment Agreement, dated July 1, 2005, between Robert M. Thornton, Jr. and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.1 of the Company’s Report on Form 8-K filed December 23, 2005). (Commission File No. 051285094)
10.3*	2005 Equity Incentive Plan (incorporated by reference from Exhibit 99.1 of the Company’s Registration Statement on Form S-8 filed September 20, 2006). (Commission File No. 061100389)
10.4	Agreement of Understanding, dated June 28, 2007, between Christopher H. B. Mills and SunLink Health Systems, Inc. (incorporated by reference from Exhibit 99.2 of the Company’s Report on Form 8-K filed July 16, 2007). (Commission File No. 07982325)
10.5*	Employment letter dated September 23, 2010 with an effective date of September 30, 2010, by and between SunLink ScriptsRx, LLC and Byron D. Finn (incorporated by reference from the Company’s Annual Report on Form 10-K for the year ended June 30, 2011). (Commission File No. 111108066)
10.6	Mortgage Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company’s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676)
10.7	Working Capital Loan Agreement dated as of July 5, 2012, by and between Stillwater National Bank and Southern Health Corporation of Houston, Inc. (incorporated by reference from the Company’s Annual Report on Form 10-K for the year ended June 30, 2012). (Commission File No. 121102676)

10.8 Amendment and Waiver to Mortgage Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (Incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205)

10.9 Amendment and Waiver to Working Capital Loan Agreement as of May 14, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013). (Commission File No. 13848205)

10.10 Second Amendment and Waiver to Mortgage Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753)

10.11 Second Amendment and Waiver to Working Capital Loan Agreement as of June 28, 2013, among Southern Health Corporation of Houston, Inc., MedCare South, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2013). (Commission File No. 131119753)

10.12 Third Amendment and Waiver to Mortgage Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2014). (Commission File No. 1141123931)

10.13 Third Amendment and Waiver to Working Capital Loan Agreement as of June 30, 2014, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2014). (Commission File No. 1141123931)

10.14* 2011 Director Stock Option Plan (incorporated by reference from Appendix A to the Company's Schedule 14A Definitive Proxy Statement filed September 29, 2011) (Commission File No. 111115265).

10.15 Fourth Amendment effective July 5, 2015, among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc., and Stillwater National Bank and Trust Company. (incorporated by reference from the Company's Annual Report on Form 10-K for the year ended June 30, 2015). (Commission File No. 151125045)

10.16 Limited Waiver to Mortgage Loan Agreement as of March 31, 2016 among Southern Health Corporation of Houston, Inc. Crown Healthcare Investments, LLC SunLink Health Systems, Inc. and Bank SNB. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016). (Commission File No. 161646127)

10.17 Limited Waiver to Working Capital Loan Agreement as of March 31, 2016 among Southern Health Corporation of Houston, Inc. Crown Healthcare Investments, LLC SunLink Health Systems, Inc. and Bank SNB. (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016). (Commission File No. 161646127)

10.18 Limited Waiver dated August 10, 2016 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB. (incorporated by reference from the Company's Current Report on Form 8-K filed August 25, 2016) (Commission File No. 161851572)

10.19 Fourth Amendment to Loan Agreement and Waiver dated January 6, 2017 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB, National Association (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended December 31, 2016). (Commission File No. 17609813)

10.20 Fifth Amendment to Loan Agreement, Modification of Note and Waiver dated December 26, 2017 among Southern Health Corporation of Houston, Inc., Crown Healthcare Investments, LLC, SunLink Health Systems, Inc. and Bank SNB National Association (incorporated by reference from the Company's Quarterly Report on Form 10-Q for the quarter ended December 31, 2017). (Commission File No. 18613104)

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* Management contract or compensatory plan or arrangement.

^ Filed herewith.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, SunLink Health Systems, Inc. has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized, on this 27th day of September, 2019.

SUNLINK HEALTH SYSTEMS, INC.

By: /s/ Robert M. Thornton, Jr.
Robert M. Thornton, Jr.
Chairman and Chief Executive Officer

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

Name	Title	Date
/s/ Robert M. Thornton, Jr. **Robert M. Thornton, Jr.**	Director, Chairman, President and Chief Executive Officer (principal executive officer)	September 27, 2019
/s/ Mark J. Stockslager **Mark J. Stockslager**	Chief Financial Officer and Principal Accounting Officer (principal accounting officer)	September 27, 2019
/s/ Steven J. Baileys, D.D.S. **Steven J. Baileys, D.D.S.**	Director	September 27, 2019
/s/ Gene E. Burleson **Gene E. Burleson**	Director	September 27, 2019
/s/ C. Michael Ford **C. Michael Ford**	Director	September 27, 2019
/s/ Christopher H. B. Mills **Christopher H. B. Mills**	Director	September 27, 2019
/s/ Howard E. Turner **Howard E. Turner**	Director	September 27, 2019

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of
SunLink Health Systems, Inc.

We have audited the consolidated financial statements of SunLink Health Systems, Inc. (the "Company") as of June 30, 2019 and 2018 and for each of the years in the two-year period ended June 30, 2019, and have issued our report, which expressed an unqualified opinion on those consolidated financial statements, thereon dated September 25, 2019. The supplemental information contained in Schedule II Valuation and Qualifying Accounts has been subjected to audit procedures performed in conjunction with the audit of the Company's consolidated financial statements. The supplemental information is the responsibility of the Company's management. Our audit procedures included determining whether the supplemental information reconciles to the consolidated financial statements or the underlying accounting and other records, as applicable, and performing procedures to test the completeness and accuracy of the information presented in the supplemental information. In forming our opinion on the supplemental information, we evaluated whether the supplemental information, including its form and content, is presented in conformity with accounting principles generally accepted in the United States of America. In our opinion, the supplemental information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

/s/Cherry Bekaert LLP

Atlanta, Georgia
September 27, 2019

SUNLINK HEALTH SYSTEMS, INC. AND SUBSIDIARIES

SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
(amounts in thousands)

Column A	Column B	Column C		Column D	Column E
Allowance for Doubtful Accounts	**Balance at Beginning Of Year**	**Charged to Cost and Expenses**	**Currency Translation/ Acquisition/ (Disposition)**	**Deductions from Reserves**	**Balance at End of Year**
Year Ended June 30, 2019	$ 529	$ 807	$ —	$ (821)	$ 515
Year Ended June 30, 2018	$ 552	$ 1,212	$ —	$ (1,235)	$ 529

Deferred Income Tax Asset Valuation Allowance	**Balance at Beginning Of Year**	**Charged to Cost and Expenses/ (Benefit)**	**Currency Translation/ Acquisition/ (Disposition)**	**Deductions from Reserves**	**Balance at End of Year**
Year Ended June 30, 2019	$ 8,373	$ 252	$ —	$ —	$ 8,625
Year Ended June 30, 2018	$ 11,120	$ (2,747)	$ —	$ —	$ 8,373

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
SunLink Health Systems, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of SunLink Health Systems, Inc. (the "Company") as of June 30, 2019 and 2018, and the related consolidated statements of operations and comprehensive earnings and loss, shareholders' equity, and cash flows for each of the years in the two-year period ended June 30, 2019, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of June 30, 2019 and 2018, and the results of its operations and its cash flows for each of the years in the two-year period ended June 30, 2019, in conformity with accounting principles generally accepted in the United States of America.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) ("PCAOB") and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits, we are required to obtain an understanding of internal control over financial reporting, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

We have served as the Company's auditor since 2004.

/s/ Cherry Bekaert LLP

Atlanta, Georgia

September 27, 2019

SUNLINK HEALTH SYSTEMS, INC.
CONSOLIDATED BALANCE SHEETS
JUNE 30, 2019 AND 2018
(All Amounts in thousands)

	2019	2018
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 7,742	$ 3,456
Receivables—net	4,715	4,823
Inventory	2,016	1,854
Prepaid expenses and other assets	2,185	2,977
Total current assets	16,658	13,110
PROPERTY, PLANT AND EQUIPMENT		
Land	273	754
Buildings and improvements	5,429	5,823
Equipment and fixtures	13,818	13,290
	19,520	19,867
Less accumulated depreciation	14,277	13,971
Property, plant and equipment—net	5,243	5,896
NONCURRENT ASSETS:		
Intangible assets—net	1,353	1,470
Income tax receivable	153	305
Assets held for sale	249	4,510
Other noncurrent assets	763	885
Total noncurrent assets	2,518	7,170
TOTAL ASSETS	$ 24,419	$ 26,176
LIABILITIES AND SHAREHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Accounts payable	$ 1,564	$ 1,239
Current maturities of long-term debt, net of debt issuance costs	2,836	255
Accrued payroll and related taxes	1,960	1,959
Accrued sales tax payable	843	241
Other accrued expenses	1,207	1,157
Total current liabilities	8,410	4,851
LONG-TERM LIABILITIES:		
Long-term debt, net of debt issuance costs	127	2,803
Noncurrent liability for professional liability risks	705	996
Other noncurrent liabilities	134	340
Total long-term liabilities	966	4,139
COMMITMENTS AND CONTINGENCIES		
SHAREHOLDERS' EQUITY:		
Preferred Shares, authorized and unissued, 2,000 shares	0	0
Common Shares, no par value; authorized, 12,000 shares; issued and outstanding, 6,987 shares at June 30, 2019 and 7,347 shares at June 30, 2018	3,493	3,673
Additional paid-in capital	10,745	10,947
Retained earnings	1,058	2,743
Accumulated other comprehensive loss	(253)	(177)
Total Shareholders' Equity	15,043	17,186
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ 24,419	$ 26,176

See notes to consolidated financial statements.

SUNLINK HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
AND COMPREHENSIVE EARNINGS AND LOSS
FOR THE YEARS ENDED JUNE 30, 2019 and 2018
(All amounts in thousands, except per share amounts)

	2019	2018
Net Revenues	$ 45,618	$ 45,209
Costs and expenses:		
Cost of goods sold	18,941	18,529
Salaries, wages and benefits	19,191	18,610
Supplies	1,241	1,238
Purchased services	2,508	2,162
Other operating expenses	3,895	3,657
Rent and lease expense	609	615
Impairments	129	0
Depreciation and amortization	1,486	1,531
Electronic Health Records incentive payments	(68)	(21)
Operating loss	(2,314)	(1,112)
Other income (expense):		
Gain on economic damages claim, net	22	944
Interest expense, net	(241)	(359)
Loss on extinguishment of debt—net	0	(238)
Gain on sale of assets—net	455	194
Loss from continuing operations before income taxes	(2,078)	(571)
Income tax benefit	(82)	(345)
Loss from continuing operations	(1,996)	(226)
Earnings (loss) from discontinued operations, net of income taxes	242	(1,367)
Net loss	(1,754)	(1,593)
Other comprehensive income (loss)	(76)	150
Comprehensive loss	$ (1,830)	$ (1,443)
Earnings (loss) per share:		
Continuing operations:		
Basic	$ (0.28)	$ (0.03)
Diluted	$ (0.28)	$ (0.03)
Discontinued operations:		
Basic	$ 0.03	$ (0.17)
Diluted	$ 0.03	$ (0.17)
Net loss:		
Basic	$ (0.25)	$ (0.19)
Diluted	$ (0.25)	$ (0.19)
Weighted-average common shares outstanding:		
Basic	7,149	8,283
Diluted	7,149	8,283

See notes to consolidated financial statements.

SUNLINK HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY
FOR THE YEARS ENDED JUNE 30, 2019 AND 2018
(All amounts in thousands)

	Common Shares		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Shareholders' Equity
	Shares	Amount				
JUNE 30, 2017	9,163	$ 4,581	$ 13,103	$ 4,336	$ (327)	$ 21,693
Net loss	0	0	0	(1,593)	0	(1,593)
Minimum pension liability adjustment, net of tax of $103	0	0	0	0	150	150
Share-based compensation	0	0	8	0	0	8
Shares repurchased	(1,816)	(908)	(2,164)	0	0	(3,072)
JUNE 30, 2018	7,347	$ 3,673	$ 10,947	$ 2,743	$ (177)	$ 17,186
Net loss	0	0	0	(1,754)	0	(1,754)
Minimum pension liability adjustment, net of tax of $0	0	0	0	0	(7)	(7)
Adoption of ASU 2018-02	0	0	0	69	(69)	0
Share-based compensation	0	0	1	0	0	1
Shares repurchased	(360)	(180)	(203)	0	0	(383)
JUNE 30, 2019	6,987	$ 3,493	$ 10,745	$ 1,058	$ (253)	$ 15,043

See notes to consolidated financial statements.

SUNLINK HEALTH SYSTEMS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2019 AND 2018
(All amounts in thousands)

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES		
Net loss	$ (1,754)	$ (1,593)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:		
Depreciation and amortization	1,728	1,858
Share-based compensation	1	8
Impairments	129	0
Gain on sale of Parkside	(2,136)	0
Gain on disposal of property, plant and equipment	(455)	(194)
Loss on sale of Chestatee	0	113
Change in assets and liabilities:		
Receivables	108	1,083
Inventory	(162)	132
Prepaid expenses and other assets	1,049	12
Accounts payable and accrued expenses	1,190	(391)
Third-party payor settlements	(218)	(368)
Net activities of discontinued operations	(907)	(264)
Net cash provided by (used in) operating activities	(1,427)	396
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from sale of Parkside	6,899	0
Proceeds from sale of property, plant & equipment	937	425
Expenditures for property, plant and equipment—continuing operations	(1,272)	(1,132)
Expenditures for property, plant and equipment—discontinued operations	(172)	(729)
Net cash provided by (used in) investing activities	6,392	(1,436)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Repurchase of common shares	(383)	(3,072)
Receipt of restricted cash	0	1,000
Payment of long-term debt – continuing operations	(296)	(3,926)
Net cash used in financing activities	(679)	(5,998)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	4,286	(7,038)
CASH AND CASH EQUIVALENTS:		
Beginning of year	3,456	10,494
End of year	$ 7,742	$ 3,456
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid for:		
Income taxes	$ 0	$ 0
Interest	$ 222	$ 319

See notes to consolidated financial statements.

1. BUSINESS OPERATIONS

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

Healthcare Services

- 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 psychology unit ("GPU"), and a 66-bed nursing home. This facility focuses primarily on senior healthcare services.
- A subsidiary which owns a medical building and approximately four (4) acres of land in Clanton, Alabama. A portion of the medical office building is currently partially rented to two tenants.
- A subsidiary which owns 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, SunLink Health Systems Technology (SHS Technology), which provides information technology (IT) to outside customers and to SunLink subsidiaries.

Pharmacy

The Pharmacy segment, which 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, assisted living facilities, behavioral and 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 settings including private residential homes.
- 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.

SunLink subsidiaries have conducted the Healthcare Services business since 2001 and the Pharmacy operations since 2008. Our Pharmacy segment currently is operated through Carmichael's Cashway Pharmacy, Inc. ("Carmichael"), a subsidiary of our SunLink ScriptsRx, LLC subsidiary.

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 the publicly traded Company or any particular subsidiary of the Company owns or operates any asset, business or property. The Trace, pharmacy operations and businesses described in this filing are owned and operated by distinct and indirect subsidiaries of SunLink Health System, Inc.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation — The consolidated financial statements include the accounts of SunLink and its subsidiaries. All significant intercompany transactions and balances have been eliminated.

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

Net Patient Service Revenue — Effective July 1, 2018, the Company adopted the provisions of Accounting Standards Codification ("ASC") 606, "Revenue from Contracts with Customers" ("ASC 606"), which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance, by applying the full retrospective method for all periods presented. ASC 606 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

The adoption of the provisions of ASC 606 had no material impact on the Company's current or historical financial position, results of operations or cash flows. Additionally, management does not anticipate that the provisions of ASC 606 will have a material impact on the amount or timing of when the Company recognizes revenue prospectively. However, in accordance with ASC 606, the Company now recognizes the majority of its previously reported provision for doubtful accounts, primarily related to its self-pay patient population, as a direct reduction to revenues as an implicit pricing concession, instead of separately as a discrete deduction to arrive at revenue, and the related presentation of the allowance for doubtful accounts has been eliminated for all periods presented. Subsequent material events that alter the payor's ability to pay are recorded as bad debt expense. The Company's revenue recognition and accounts receivable policies are more fully described in Note 5.

SunLink's subsidiaries have agreements with third-party payors that provide for payments at amounts different from established charges. Payment arrangements vary and include prospectively determined rates per discharge, reimbursed costs, discounted charges and per diem payments. Patient service revenues are reported as services are rendered at the estimated net realizable amounts from patients, third-party payors, and others. Estimated net realizable amounts are estimated based upon contracts with third-party payors, published reimbursement rates, and historical reimbursement percentages pertaining to each payor type. Estimated reductions in revenues to reflect agreements with third-party payors and estimated retroactive adjustments under such reimbursement agreements are accrued during the period the related services are rendered and are adjusted in future periods as interim and final settlements are determined. Significant changes in reimbursement levels for services under government and private programs could significantly impact the estimates used to accrue such revenue deductions. At June 30, 2019, there were no material claims or disputes with third-party payors.

Charity Care —SunLink's subsidiary hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because SunLink subsidiaries do not pursue collection of amounts determined to qualify as charity, they are not reported as revenue. SunLink's subsidiary hospital provided $48 and $8, of charity care in the fiscal years ended June 30, 2019 and 2018, respectively.

Concentrations of Credit Risk —SunLink's Healthcare Services segment subsidiaries grant unsecured credit to their patients, most of who reside in the service area of the subsidiaries' facilities and are insured under third-party agreements. Medicare and Medicaid patient accounts represent SunLink's only significant concentrations of credit risk. For SunLink's Healthcare Services segment, Medicare net revenues were approximately 49% and 50% of net revenues for the years ended June 30, 2019 and 2018, respectively. For SunLink's Healthcare Services segment, Medicaid was approximately 33% and 31% net revenues for the years ended June 30, 2019 and 2018, respectively. For SunLink's Healthcare Services segment, Medicare receivables were approximately 42% and 45% of receivables—net at June 30, 2019 and 2018, respectively, while Medicaid receivables were approximately 26% and 36% of receivables—net at June 30, 2019 and 2018, respectively.

SunLink's Pharmacy segment subsidiary grants unsecured credit to individual customers and institutional customers. Individual customers primarily are insured under third-party agreements, including Medicare and Medicaid, while the institutional customers are granted credit according to their determined credit risk. Medicare receivables were approximately 17% and 19% of the Pharmacy segment's receivables at June 30, 2019 and 2018, respectively, while Medicaid receivables were approximately 17% and 18% of the Pharmacy segments receivable at June 30, 2019 and 2018, respectively. Approximately 66% and 63% of the Pharmacy's net receivables at June 30, 2019 and 2018, respectively, were private insurance and institutional customers' receivables. Net revenues for the Pharmacy segment for the fiscal year ended June 30, 2019 and 2018 were approximately 35% and 35% Medicare, respectively, and approximately 29% and 26% Medicaid, respectively.

Cash and Cash Equivalents —Cash and cash equivalents consist of all funds in banks and short-term liquid investments with an original maturity of three months or less. Cash is deposited with commercial banks and at June 30, 2019 was $1,742, of which approximately $762 totaled amounts greater than the federally insured limits. At June 30, 2019, the Company's cash equivalents were composed of $5,250 of overnight repurchase agreements and a $750 three-month certificate of deposit with a U.S. bank, of which the full balance of the certificate of deposit is greater than the federally insured limit. The Company accounts for these agreements as cash equivalents in accordance with FASB ASC 305-10-20. The investing of cash in amounts greater than the insurable limits with major well-capitalized financial institutions mitigates the risk of the deposited cash and the certificate of deposit. The overnight repurchase agreements are 102% collateralized by U. S. government backed securities with the Company's U.S. bank. The U.S. Government backed collateralized securities are of high credit quality which mitigates any significant risk to the credit rating or interest rate risk of the agreements.

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

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

Property, Plant, and Equipment —Property, plant, and equipment, including equipment subject to capital leases, is recorded at cost. Depreciation is recognized over the estimated useful lives of the assets, which range from 3 to 45 years, on a straight-line basis. Generally, furniture and fixtures are depreciated over 5 to 10 years, machinery and equipment over 10 years, and buildings over 25 to 45 years. Leasehold improvements and leased machinery and equipment are depreciated over the lease term or estimated useful life of the asset, whichever is shorter, and range from 5 to 15 years. For the Pharmacy segment, durable medical equipment is depreciated over 3 years. Expenditures for major renewals and replacements are capitalized. Expenditures for maintenance and repairs are charged to operating expense as incurred. When property items are retired or otherwise disposed of, amounts applicable to such items are removed from the related asset and accumulated depreciation accounts and any resulting gain or loss is credited or charged to income. Depreciation expense totaled $1,369 and $1,414 for the years ended June 30, 2019 and 2018, respectively.

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

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

The recorded liability for professional liability risks includes an estimate of liability for claims assumed at the acquisition and for claims incurred after the acquisition of a business. These amounts are based on actuarially determined estimates.

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

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

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

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

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

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

Share-Based Compensation —The Company issues common share options to key employees and directors under various shareholder-approved plans. Share-based compensation expense of $1 and $8 for the fiscal years ended June 30, 2019 and 2018, respectively, was recorded in salaries, wages and benefits expense for share options issued to employees and directors of the Company. The fair value of the share options was estimated using the Black-Scholes option pricing model. The historical volatility is used to calculate the estimated volatility in this model.

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

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

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

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

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

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

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

Earnings (Loss) per Share —Earnings (loss) per common share is based on the weighted-average number of common shares and dilutive common share equivalents outstanding for each period presented, including vested and unvested shares issued under SunLink's 2005 Equity Incentive Plan, and the 2011 Director Stock Option Plan. Common share equivalents represent the dilutive effect of the assumed exercise of the outstanding stock options.

Recent Accounting Pronouncements

In January 2017, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2017-04, which simplifies the accounting for goodwill impairment by eliminating step two from the goodwill impairment test. Instead of a two-step impairment model, if the carrying amount of a reporting unit exceeds its fair value as determined in step one of the impairment test, an impairment loss is measured at the amount equal to that excess, limited to the total amount of goodwill allocated to that reporting unit. This ASU is effective for any interim or annual impairment tests for fiscal years beginning after December 15, 2019, with early adoption permitted. The Company is evaluating what impact it will have on its consolidated financial position and results of operations.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost will be reported in the same Statement of Operations and Comprehensive Earnings and Loss line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost will be presented separately in a line item outside of operating income. This ASU was effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on July 1, 2018. The Company has only one defined benefit plan for pension which is frozen for new participants and the cost of the plan is reported in discontinued operations. Since the changes required in this new ASU only change the income statement classification of the components of net periodic benefit cost, no changes to the presentation of income from continuing operations nor net income was required.

In May 2014, the FASB issued ASU 2014-9, "Revenue from Contracts with Customers", along with subsequent amendments, updates and an extension of the effective date (collectively, the "New Revenue Standard" or "ASC 606"), which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance. This Standard was adopted July 1, 2018. See Note 5 Revenue Recognition and Accounts Receivable for further discussion.

In February 2018, the FASB issued Accounting Standards Update 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income* ("ASU 2018-02"). This ASU was effective for fiscal years beginning after December 15, 2018. The Company early adopted this ASU as of July 1, 2018 and applied its provisions during the fiscal year ended June 30, 2019, instead of retrospectively at the date of adoption. In implementing the provisions of the Tax Cuts and Jobs Act of 2017 (the "Tax Act"), the remeasurement of our deferred tax assets and liabilities was recorded as a component of our provision for income taxes. For deferred tax amounts that were originally recorded through accumulated other comprehensive income ("AOCI"), the remeasurement of deferred tax assets and liabilities through the provision for income taxes resulted in these amounts becoming "stranded" in AOCI. ASU 2018-02 permits companies to reclassify the stranded tax amounts recorded in AOCI to retained earnings, and we reclassified $69 of stranded tax effects from AOCI to retained earnings effective June 30, 2019.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a corresponding lease liability. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. The ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company is required to adopt this ASU on July 1, 2019. In July 2018, the FASB issued ASU 2018-11, which provides entities relief from the transition requirements in ASU 2016-02 by allowing them to elect not to recast prior comparative periods. The Company plans to elect this method of transition upon adoption of this ASU. Because of the few number of leases the Company utilizes to support its operations, the adoption of this ASU is not expected to have a significant impact on the Company's consolidated financial position and results of operations. Management is currently evaluating the extent of this anticipated impact on the Company's consolidated financial position and results of operations, and the quantitative and qualitative factors that will impact the Company as part of the adoption of this ASU, as well as any changes to its leasing strategy that may occur because of the changes to the accounting and recognition of leases.

3. RESTRICTED CASH

Under the Fourth Amendment to the Trace RDA Loan dated January 6, 2017 (see Note 9. Long-Term Debt), a deposit of $1,000 in a blocked interest bearing account was held by the lender. Under the Fifth Amendment to the Trace RDA Loan dated December 26, 2017, the blocked account was eliminated.

4. DISCONTINUED OPERATIONS

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

Parkside Nursing Home — On March 17, 2019, a subsidiary of the Company sold its Parkside Ellijay Nursing Home ("Parkside") and related real estate for $7,300 subject to adjustment for the book value of certain assets and liabilities on the sale date. The pre-tax gain on the sale is $2,136, which is also subject to adjustment for the book value of certain assets and liabilities on the sale date. The net proceeds of the sale were retained for working capital and general corporate purposes.

Sold Hospitals – Subsidiaries of the Company have sold substantially all of the assets of four hospitals ("Other Sold Hospitals") during the period July 2, 2012 to August 19, 2016. The income (loss) before income taxes of the Other Sold Hospitals results primarily from the effects of prior year Medicare and Medicaid cost report settlements and retained professional liability claims expenses.

Life Sciences and Engineering Segment —SunLink retained a defined benefit retirement plan which covered substantially all of the employees of this segment when the segment was sold in fiscal 1998. Effective February 28, 1997, the plan was amended to freeze participant benefits and close the plan to new participants. Pension expense and related tax benefit or expense is reflected in the results of operations for this segment for the fiscal years ended June 30, 2019 and 2018.

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

Discontinued Operations—Summary Statement of Earnings Information

	2019	2018
Net Revenues:		
Parkside	$ 5,574	$ 6,960
Sold Hospitals	(581)	82
	$ 4,993	$ 7,042
Loss Before Income Taxes:		
Parkside	$ (756)	$ (1,006)
Sold Hospitals	(919)	(89)
Life sciences and engineering	(137)	(159)
Loss before income taxes	(1,812)	(1,254)
Gain (Loss) on Sale:		
Parkside	2,136	0
Sold Hospitals	0	(113)
Gain (Loss) on Sale	2,136	(113)
Income tax expense	82	0
Earnings (Loss) from discontinued operations	$ 242	$ (1,367)

5. REVENUE RECOGNITION AND ACCOUNTS RECEIVABLES

Revenue Recognition

Effective July 1, 2018, the Company adopted the provisions of Accounting Standards Codification (“ASC”) 606, “Revenue from Contracts with Customers” which supersedes most existing revenue recognition guidance, including industry-specific healthcare guidance, by applying the full retrospective method for all periods presented. ASC 606 provides for a single comprehensive principles-based standard for the recognition of revenue across all industries through the application of the following five-step process:

Step 1: Identify the contract(s) with a customer.

Step 2: Identify the performance obligations in the contract.

Step 3: Determine the transaction price.

Step 4: Allocate the transaction price to the performance obligations in the contract.

Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

The adoption of the provisions of ASC 606 had no material impact on the Company’s current or historical financial position, results of operations or cash flows. Additionally, management does not anticipate that the provisions of ASC 606 will have a material impact on the amount or timing of when the Company recognizes revenue prospectively. However, in accordance with ASC 606 the Company now recognizes the majority of its previously reported provision for doubtful accounts, primarily related to its self-pay patient population, as a direct reduction to revenues as an implicit pricing concession, instead of separately as a discrete deduction to arrive at revenue, and the related presentation of the allowance for doubtful accounts has been eliminated for all periods presented. Subsequent material events that alter the payor’s ability to pay are recorded as bad debt expense.

Disaggregation of Revenue

The Company disaggregates revenue from contracts with its patients by reportable operating segments and payors. The Company determines that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors. A reconciliation of disaggregated revenue to segment revenue is disclosed in Note 13, Financial Information by Segment.

The Company's service specific revenue recognition policies are as follows:

Healthcare Services

The Company's revenue is derived primarily from providing healthcare services to patients and is recognized on the date services are provided at amounts billable to individual patients, adjusted for estimates for variable consideration. For patients under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts or rates, adjusted for estimates for variable consideration, on a per patient, daily basis or as services are performed.

Pharmacy

The Company's revenue is derived primarily from providing pharmacy goods and services to patients and is recognized on the date goods and services are provided at amounts billable to individual patients, adjusted for estimates for variable consideration. Revenue is recognized when control of the promised goods or services are transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. Significant portions of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third-party insurance payors, and reduces revenue at the revenue recognition date, to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total net revenues and receivables reported in the Company's financial statements are recorded at the amount expected to be ultimately received from these payors.

Medicare Revenue

Net healthcare services revenue is recorded under the Medicare prospective payment system based on an episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if patient care was unusually costly; (b) a low utilization payment adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) the number of episodes of care provided to a patient, regardless of whether the same provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments.

The Company makes adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Revenue is also adjusted for estimates for variable consideration. Therefore, the Company believes that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed services, the Company also recognizes a portion of revenue associated with services in progress. Services in progress are days of care that begin during the reporting period but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of services in progress at the end of the reporting period, expected Medicare revenue per episode and its estimate of the average percentage complete based on services performed.

Non-Medicare Revenue

The Company recognizes revenue in a similar manner as it recognizes Medicare revenue for service-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms.

Revenue is recorded on an accrual basis based upon the date of service at amounts equal to its established or estimated per-visit rates, and adjusted for estimates for variable consideration, as applicable.

Impact of New Revenue Guidance on Financial Statement Line Items

The following tables summarize the impacts of adopting ASC 606 on the Company's condensed consolidated statements of operations and comprehensive earnings (loss). There was no impact to the condensed consolidated balance sheet as of June 30, 2018 or condensed consolidated statements of cash flows for the year ended June 30, 2018. The majority of which was previously presented as bad debt expense of the Pharmacy Segment under operating expenses has been incorporated as an implicit price concession factored into the calculation of net revenues. Subsequent material events that alter the payor's ability to pay are recorded as bad debt expense.

There is no material change, related to the adoption of ASC 606, for the presentation of the Company's Fiscal 2018 revenues or prior years. Historically, the Company only presented total revenue for all revenue services in "Operating Revenues". What was previously presented as provision for bad debts of Pharmacy segment under operating expenses has been incorporated as an implicit price concession factored into the calculation of net revenues, as shown in the "Adjustments" line in the table below. The Condensed Consolidated Statement of Operations and Comprehensive Earnings (Loss) for the year June 30, 2018 has been restated to reflect the adoption of ASC 606. Subsequent material events that alter the payor's ability to pay are recorded as bad debt expense.

Prior period results reflect reclassifications, for comparative purposes, related to the adoption of ASC 606, for the presentation of the Company's revenues. Historically, the Company only presented total revenue for all revenue services. This reclassification had no effect on the reported results of operations.

Net revenues, costs of goods sold and operating expenses for the fiscal year ended June 30, 2018 as reclassified are summarized in the following tables:

	Fiscal Year Ended June 30, 2018
Operating revenues (net of contractual adjustments)	$ 46,450
Less provision for bad debts of Healthcare Services segment	(538)
Adjustment for bad debts of Pharmacy segment	(703)
Net Revenues	$ 45,209
Total Cost of goods sold	$ 18,529
Adjustment for bad debts of Pharmacy segment	0
Cost of goods sold	$ 18,529
Total Operating Expenses	$ 47,024
Adjustment for bad debts of Pharmacy segment	(703)
Total Operating Expenses	$ 46,321

Practical Expedients and Exemptions

The Company's contracts with its patients have an original duration of one year or less, therefore, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, Other Assets and Deferred Costs, and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

The Company's revenues by payor were as follows for the years ended June 30, 2019 and 2018:

	2019	2018
Medicare	$ 18,183	$ 18,446
Medicaid	13,871	12,636
Retail and Institutional Pharmacy	6,649	6,505
Managed Care & Other Insurance	6,220	6,922
Self-pay	505	502
Rent	63	68
Other	127	130
Total Net Revenues	$ 45,618	$ 45,209

Summary information for receivables is as follows:

	June 30, 2019	June 30, 2018
Patient and customer accounts receivable (net of contractual allowances)	$ 5,230	$ 5,352
Less allowance for concession allowances	(515)	(529)
Patient and customer accounts receivable—net	$ 4,715	$ 4,823

The following is a summary of the activity in the allowance for concession adjustments for the Healthcare Services segment and the Pharmacy segment for the fiscal years ended June 30, 2019 and 2018:

Fiscal year ended June 30, 2019	**Healthcare Services**	**Pharmacy**	**Total**
Balance at July 1, 2018	$ 253	$ 276	$ 529
Additions recognized as a reduction to revenues:			
Continuing operations	401	416	817
Discontinued operations	(10)	0	(10)
Accounts written off, net of recoveries	(313)	(508)	(821)
Balance at June 30, 2019	$ 331	$ 184	$ 515

Fiscal year ended June 30, 2018	**Healthcare Services**	**Pharmacy**	**Total**
Balance at July 1, 2017	$ 328	$ 224	$ 552
Additions recognized as a reduction to revenues:			
Continuing operations	538	703	1,241
Discontinued operations	(29)	0	(29)
Accounts written off, net of recoveries	(584)	(651)	(1,235)
Balance at June 30, 2018	$ 253	$ 276	$ 529

Net revenues included a decrease of $15 for the year ended June 30, 2019 from the settlement of prior year Medicare and Medicaid cost reports. Net revenues included an increase of $135 for the year ended June 30, 2018 from the settlement of prior year Medicare and Medicaid cost reports.

6. INVENTORY

Inventory consisted of the following:

	June 30, 2019	June 30, 2018
Healthcare Services segment, supplies inventory	$ 157	$ 155
Pharmacy segment, goods held for sale	1,859	1,699
	$ 2,016	$ 1,854

7. IMPAIRMENT OF LONG-LIVED ASSETS

Impairment of Note Receivable— In conjunction with the 2014 settlement of a lawsuit, the Company received a five-year promissory note in the principal amount of $600 maturing in October 2019. The note was secured by a non-recourse mortgage on an approximately 24.74 acres of real property in Ellijay, Georgia. The terms of the Note and mortgage provide that if the owner of the real property did not pay the note at maturity, then the Company may foreclose and take title of the real property. The obligors have notified the Company that they propose conveying the real property to the Company in lieu of payment of the note. The market value of the note was estimated to be $500 when received based on an appraisal of the real property at that time. A subsequent appraisal of the real property has reduced the value of the property to $371. As a result, an impairment of the note of $129 has been recorded in the fourth quarter of the fiscal year ended June 30, 2019. The Company expects to obtain title to the real property in full satisfaction of the note in the fiscal year ending June 30, 2020.

Impairment of Intangible Assets— See footnote 8. Intangible Assets for discussion of impairment analysis of Intangible Assets.

Impairment analysis —For the purposes of these analyses, our estimates of fair value are based on a combination of the income approach, which estimates the fair value based on future discounted cash flows, and the market approach, which estimates the fair value based on comparable market prices. Estimates of fair value for reporting units fall under Level 3 of the fair value hierarchy. Estimates of future discounted cash flows are based on assumptions and projections we believe to be currently reasonable and supportable. These assumptions take into account revenue and expense growth rates, patient volumes, changes in payor mix, and changes in legislation and other payor payment patterns.

8. INTANGIBLE ASSETS

SunLink's Pharmacy segment has intangible assets related to its Carmichael acquisition, which consists of:

Intangible assets:

	June 30, 2019	June 30, 2018
Pharmacy segment		
Trade Name	$ 1,180	$ 1,180
Customer Relationships	1,089	1,089
Medicare License	623	623
	2,892	2,892
Accumulated Amortization	(1,539)	(1,422)
Total	$ 1,353	$ 1,470

Impairment testing —During the fourth quarters of fiscal 2019 and 2018, we completed our annual impairment test of certain intangible assets and no impairment was indicated.

The Trade Name intangible asset under the Pharmacy segment is a non-amortizing intangible asset. Customer Relationships intangible asset is being amortized over 12 years and Medicare License intangible asset is being amortized over 15 years. Amortization expense was $117 for the fiscal years ended June 30, 2019 and 2018, respectively.

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

2020	$ 100
2021	26
2022	26
2023	21
2024 and thereafter	0
Total	$ 173

9. LONG-TERM DEBT

Long-term debt consisted of the following:

	June 30, 2019	June 30, 2018
Trace RDA Loan	$ 2,999	$ 3,277
Capital lease obligations	159	0
Total	3,158	3,277
Less unamortized debt costs	(195)	(219)
Less current maturities	(2,836)	(255)
	$ 127	$ 2,803

Trace RDA Loan— Southern Health Corporation of Houston, Inc. ("Trace") a wholly owned subsidiary of the Company, closed on a $9,975 Mortgage Loan Agreement ("Trace RDA Loan") with a bank, dated as of July 5, 2012. The Trace RDA Loan has a term of 15 years with level monthly payments of principal and interest until repaid. On December 26, 2017, the Fifth Amendment to Loan Agreement, Modification of Note and Waiver ("Modification") was entered into by Trace and the bank. Under the Modification, Trace made a $3,548 prepayment on the Trace RDA Loan. The monthly principal and interest payments on the Trace RDA Loan were reduced, the interest rate was reduced to the prime rate (as published in the Wall Street Journal) plus 1% with a floor of 5.5%, (6.5% at June 30, 2019) and certain loan covenants were modified. The Trace RDA Loan is collateralized by real estate and equipment of Trace in Houston, MS, and is partially guaranteed under the U.S. Department of Agriculture, Rural Development Business and Industry Program.

The Trace RDA Loan contains various terms and conditions, including financial restrictions and limitations, and affirmative and negative covenants. The loan is guaranteed by SunLink. At June 30, 2019, Trace was not in compliance with the debt service coverage, fixed charge coverage and funded debt to EBITDA ratios. The Company is discussing with the lender a waiver of this non-compliance but a waiver of non-compliance has not been received as of the date of the filing of this report. Since Trace was in non-compliance with these covenants at a measurement date, if the lender were to declare an event of default and accelerate the maturity of the indebtedness, either Trace or SunLink under its guarantee could be required to repay the loan in advance of its maturity which would require a substantial amount of our cash and any such repayment could restrict our current and future operations, which could negatively affect our ability to manage our operations and liquidity. No event of default has been declared by the lender as of the date of the filing of this report nor is such a declaration currently anticipated .

The Company continues to discuss a waiver to this non-compliance but a waiver of the non-compliance has not been received as of September 27, 2019. Indebtedness of $2,535, net of unamortized debt costs, as of June 30, 2019, is presented in current liabilities in the consolidated balance sheet as a result of the financial covenant non-compliance at that date. The ability of Trace to continue to make the required debt service payments under the Trace RDA Loan depends on, among other things, its ability to generate sufficient cash, including from operating activities and asset sales. If Trace is unable to generate sufficient cash to meet debt service payments on the Trace RDA Loan, including in the event the lender were to declare an event of default and accelerate the maturity of the indebtedness, such failure could have material adverse effects on the Company. The Trace RDA Loan is guaranteed by the Company and one subsidiary.

Debt Commitments —Annual required payments of debt and contractual commitments for interest on long-term debt are shown in the following table. The interest rate on variable interest debt is calculated at the interest rate at June 30, 2019.

	Debt	Interest
2020	$ 3,031	$ 186
2021	34	8
2022	36	5
2023	39	3
2024	18	0
Total	$ 3,158	$ 202

10. SHAREHOLDERS' EQUITY

Employee and Directors Stock Option Plans —The 2011 Director Stock Option Plan was approved by SunLink's shareholders at the Annual Meeting of Shareholders on November 7, 2011. This plan permits the grant of options to non-employee directors of SunLink for the purchase of up to 300,000 common shares through November 2021. No options were granted during the fiscal years ended June 30, 2019 and 2018, respectively. No options have been exercised under this plan. Options outstanding under the plan were 250,000 shares at June 30, 2019. Options for 50,000 shares may be granted under this Plan.

The 2005 Equity Incentive Plan was approved by SunLink's shareholders at the Annual Meeting of Shareholders on November 7, 2005. This plan permitted the grant of options to employees, non-employee directors and service providers of SunLink for the purchase of up to 800,000 common shares plus the number of unused shares under the 2001 Plans, which is 30,675, by November 2015. This Plan restricted the number of Incentive Stock Options to 700,000 shares and Restricted Stock Awards to 200,000 shares. The combination of Incentive Stock Options and Restricted Stock Awards cannot exceed 800,000 shares plus the number of unused shares under the 2001 Plans. Each award of Restricted Shares reduces the number of share options to be granted by four option shares for each Restricted Share awarded. No options have been exercised under this Plan. No options shares were granted during the fiscal years ended June 30, 2019 and 2018, respectively. Options outstanding under this Plan were 345,000 at June 30, 2019. No additional awards may be granted under this Plan.

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

	Number of Shares		Weighted-Average Exercise Price	Range of Exercise Prices
Options outstanding June 30, 2017	680,142	$	1.80	$0.71 - $8.00
Granted	0		N/A	N/A
Forfeited	(29,142)		8.00	8.00
Options outstanding June 30, 2018	651,000	$	1.52	$0.71 - $2.51
Granted	0		N/A	N/A
Forfeited	(56,000)		1.46	$0.71 - $2.51
Options outstanding June 30, 2019	595,000	$	1.53	$0.71 - $2.09
Options exercisable June 30, 2018	636,000	$	1.52	$0.71 - $2.51
Options exercisable June 30, 2019	595,000	$	1.53	$0.71 - $2.09

For the fiscal years ended June 30, 2019 and 2018, the Company recognized $1 and $8, respectively, of compensation expense for share options issued. As of June 30, 2019, there was no unrecognized compensation cost related to nonvested share-based compensation arrangements granted under the Plans.

Information with respect to stock options outstanding and exercisable at June 30, 2019 is as follows:

	Exercise Prices	Number Outstanding	Weighted-Average Remaining Contractual Life (in years)	Number Exercisable
$	0.71	15,000	4.22	15,000
$	1.21	60,000	7.21	60,000
$	1.22	190,000	3.18	190,000
$	1.49	90,000	5.19	90,000
$	1.67	50,000	2.37	50,000
$	1.79	70,000	6.20	70,000
$	2.09	120,000	2.20	120,000
		595,000	4.01	595,000

No options were exercised during the years ended June 30, 2019 and 2018. As of June 30, 2019 and 2018, the aggregate intrinsic value of options outstanding and options exercisable were $74 and $0, respectively.

Common Share Purchase Transactions

Common Share Purchase Tender Offer – On November 21, 2017. SunLink commenced a tender offer for the purchase of a portion of its common shares at a price of $1.60 per share (the "Offer"). The offer expired on December 21, 2017 with 3,726,000 common shares tendered. In accordance with the terms and conditions of the Offer, the Company accepted for payment a total of approximately 1,746,000 shares at a price of $1.60 per share for a total cost of $2,794, excluding fees and expenses relating to the offer.

Common Share Purchase – On June 5, 2018, the Company purchased 70,000 common shares for $1.40 per share, or $98 in total, from a director of the Company at a price equal to the closing price on that date of the Company's shares on the NYSE American Exchange. This purchase was approved on June 1, 2018 by the Executive Committee of the Company' Board of Directors.

Common Share Repurchase Program – On November 29, 2018, the Company announced a share repurchase program ("Program") approved by its Board of Directors, which authorized the Company to purchase up to 300,000 shares of its common shares. On December 13, 2018, the Company announced it had purchased the 300,000 shares authorized under the program, and that its Board of Directors had authorized an additional 450,000 shares to be purchased under the Program. As of June 30, 2019, a total of 359,959 shares had been repurchased at a cost of $372, excluding fees and expensing relating to the Program. Additional shares of 390,041 remain authorized to be repurchased. The chart below shows by month the total shares repurchased and average price per share paid for the Program as of June 30, 2019.

	Total Shares Purchased	Average Price Per Share Paid
November 2018	1,235	$ 1.14
December 2018	358,724	1.03
Total	359,959	$ 1.03

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

	Minimum Pension Liability Adjustment	Accumulated Other Comprehensive Loss
June 30, 2017	$ (327)	$ (327)
Current period change	150	150
June 30, 2018	$ (177)	$ (177)
Current period change	(76)	(76)
June 30, 2019	$ (253)	$ (253)

11. INCOME TAXES

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

	2019	2018
Current	$ 0	$ 0
Deferred	(82)	(345)
Total income tax expense (benefit)	$ (82)	$ (345)

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

	June 30, 2019	June 30, 2018
Net operating loss carryforward	$ 6,766	$ 6,367
Depreciation expense	46	(97)
Allowances for receivables	125	111
Accrued expenses	603	617
Intangible assets	877	1,185
Pension liabilities	141	132
Other	67	58
	8,625	8,373
Less valuation allowance	(8,625)	(8,373)
Net deferred income tax assets	$ 0	$ 0

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

	2019	2018
Income tax benefit at Federal statutory rate	$ (436)	$ (407)
Changes in valuation allowance—continuing operations	378	(2,889)
U.S. state income taxes, net of federal benefit	(45)	1
Deferred tax rate changes	32	2,971
Other	(11)	(21)
Total income tax benefit—continuing operations	$ (82)	$ (345)

In accordance with the Financial Accounting Standards Board Accounting Standards Codification (‘ASC”) 740, we evaluate our deferred taxes quarterly to determine if adjustments to our valuation allowance are required based on the consideration of available positive and negative evidence using a “more likely than not” standard with respect to whether deferred tax assets will be realized. Our evaluation considers, among other factors, our historical operating results, our expectation of future results of operations, the duration of applicable statuary carryforward periods and conditions of the healthcare industry. The ultimate realization of our deferred tax assets depends primarily on our ability to generate future taxable income during the periods in which the related temporary differences in the financial basis and the tax basis of the assets become deductible. The value of our deferred tax assets will depend on applicable income tax rates.

The Tax Cuts and Jobs Act (“TCJA”) was enacted on December 22, 2017. Under ASC 740, the impact of changes in tax law must be recorded in the financial statements in the reporting period that included the date of enactment. In addition, in conjunction with the TCJA, on December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118, Income Tax Accounting Implications of the Tax Cuts and Jobs Act (“SAB 118”), which provides guidance on accounting for the tax effects of the TCJA. SAB 118 allows for recording certain effects of the TCJA as “provisional” during a one-year measurement period, which for the Company ended in the second quarter of fiscal 2019.

At June 30, 2019, consistent with the above process, we evaluated the need for a valuation against our deferred tax assets and determined that it was more likely than not that none of our deferred tax assets would be realized. As a result, in accordance with ASC 740, we recognized a valuation allowance of $8,625 against the deferred tax asset so that there is no net long-term deferred income tax asset or liability at June 30, 2019. We conducted our evaluation by considering available positive and negative evidence to determine our ability to realize our deferred tax assets. In our evaluation, we gave more significant weight to evidence that was objective in nature as compared to subjective evidence. Also, more significant weight was given to evidence that directly related to our current financial performance as compared to less current evidence and future plans.

The principal negative evidence that led us to determine at June 30, 2019 that all the deferred tax assets should have full valuation allowances was the three-year cumulative pre-tax loss from continuing operations as well as the underlying negative business conditions for rural healthcare businesses in which our Healthcare Services Segment businesses operate.

For Federal income tax purposes, at June 30, 2019, the Company had approximately $16,700 of estimated net operating loss carry-forwards available for use in future years subject to the limitations of the provisions of Internal Revenue Code Section 382. These net operating loss carryforwards expire primarily in fiscal 2023 through fiscal 2038; however, with the enactment of the TCJA on December 22, 2017, federal net operating loss carryforwards generated in taxable years beginning after December 31, 2017 now have no expiration date. The Company’s returns for the periods prior to the fiscal year ended June 30, 2016 are no longer subject to potential federal and state income tax examination.

We recorded a discrete net tax benefit of $0 during the year ended June 30, 2018 related to provisional amounts under SAB 118 for the remeasurement of U.S. deferred tax assets and liabilities due to the Federal tax rate reduction to 21%. No net tax benefit was recorded due to the Company’s full valuation allowance position. The $296 of tax benefit recorded for the year ended June 30, 2018 was due to the release of the valuation allowance on the Company’s Alternative Minimum Tax (“AMT”) Credit, which became refundable under the TCJA. The final amount of AMT Credit valuation allowance release at June 30, 2018 was $305 due to adjustments made from the final June 30, 2017 tax return filing during the fourth quarter ended fiscal 2018. We also recorded an additional $40 of tax benefit at June 30, 2018 unrelated to the remeasurement of U. S. deferred tax assets and liabilities. No changes were recorded to this provisional estimate during the year ended June 30, 2019. Pursuant to the requirements of SAB 118 as discussed above the Company has completed its accounting for the TCJA for the second quarter ended fiscal 2019.

12. EMPLOYEE BENEFITS

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

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

At June 30, 2019, the plan's assets were invested 44% in cash and short term investments, 38% in equity investments and 18% in fixed income investments. The plan's current investment policy of primarily investing in cash and short term investments is based on the possible need for immediate liquidity as participants withdraw from the plan. The expected return on investment of 4% is based upon the plan's historical return on assets. The plan expects to pay $88, $50, $48, $59, and $57 in pension benefits in the years ending June 30, 2020 through 2024, respectively. The plan expects to pay $430 in pension benefits for the years June 30, 2025 through 2029, in the aggregate. This assumes the plan participants elect to take monthly pension benefits as opposed to a lump sum payout when they reach age 65. The Company made a contributions of $107 and $100 to the plan during the years ended June 30, 2019 and 2018, respectively, and plans to make a contribution of $132 to the plan for the year ended June 30, 2020.

The components of net pension expense for all plans (comprised solely of one domestic plan) were as follows for the fiscal years ended June 30, 2019 and 2018:

	2019	2018
Service cost	$ 0	$ 0
Interest cost	56	55
Expected return on assets	(36)	(36)
Amortization of prior service cost	78	125
Settlement cost	39	15
Net pension expense	$ 137	$ 159
Weighted-average assumptions:		
Discount rate	4.10%	3.80%
Expected return on plan assets	4.00%	4.00%
Rate of compensation increase	0.00%	0.00%

Summary information for the plans (comprised solely of one domestic plan) is as follows for the fiscal years ended June 30, 2019 and 2018:

	2019	2018
Change in Benefit Obligation:		
Benefit obligation at beginning of year	$ 1,420	$ 1,506
Interest cost	56	55
Actuarial (gain)loss	90	(47)
Benefits paid	(176)	(94)
Benefit obligation end of year	$ 1,390	$ 1,420
Change in Fair Value of Plan Assets:		
Beginning fair value	$ 895	$ 891
Actual return on plan assets	1	(2)
Employer contribution	107	100
Benefits paid	(176)	(94)
Plan assets at end of year	$ 827	$ 895
Funded status of the plans	(563)	(525)
Unrecognized actuarial loss	384	376
Prepaid (accrued) benefit cost	$ (179)	$ (149)
Amounts Recognized in Consolidated Balance Sheets		
Prepaid (accrued) benefit cost	(179)	(149)
Accumulated other comprehensive loss*	384	376
Net amount recognized	$ (563)	$ (525)

* Accumulated other comprehensive loss represents minimum pension liability adjustments.

Defined Contribution Plan —SunLink has a defined contribution plan pursuant to IRS Section 401(k) covering substantially all domestic employees. SunLink matches a specified percentage of the employee's contribution as determined periodically by its management. A match of $85 was provided for the fiscal year ended June 30, 2019. A match of $157 was provided for the fiscal year ended June 30, 2018. Plan expense for the defined contribution plan was $0 for the years ended June 30, 2019 and 2018.

13. ECONOMIC DAMAGES

The Pharmacy Segment subsidiary asserted claims for economic damages in connection with the Deepwater Horizon Settlement Program related to the event which occurred in 2010. In January 2018, these claims were settled and payments of approximately $22 and $944 (net of costs and attorneys' fees) for years ended June 30, 2019 and 2018 were received. The net settlements are recognized as a gain in the results for those respective years.

14. SALE OF ASSETS

On October 11, 2018, the Company sold a vacant medical office building and approximately two adjacent acres of undeveloped land. After expenses, the Company received net proceeds from the sale of $935, which was retained for working capital and general corporate purposes. The pre-tax gain on the sale of property was $452 and is included in the results for the year ended June 30, 2019.

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

15. COMMITMENTS AND CONTINGENCIES

Leases **—**The Company leases various land, buildings, and equipment under operating lease obligations having noncancelable terms ranging from one to 7 years. Rent expense was $609 and $615 for the years ended June 30, 2019 and 2018, respectively. Minimum lease commitments as of June 30, 2019 are as follows:

Fiscal year ending June 30:		
2020	$	592
2021		330
2022		129
2023		3
2024		0
	$	1,054

16. SALES TAX PAYABLE

During the fiscal year ended June 30, 2019, the Pharmacy segment business amended its sales tax position to exempt from sale tax consideration any revenue from sales of products and services to beneficiaries of government insurance programs reimbursed by administrators of such programs. No sales taxes are included in the related reimbursement received from sales of such products and services from the government payers' insurance programs. Since this position could be challenged by state and local taxing authorities, the Company has continued to accrue the sales tax payment that could be payable if this amended position is challenged and the Company does not prevail.   The sales tax accrued at June 30, 2019 is $843 compared to $241 at June 30, 2018.

17. RELATED PARTIES

A director of the Company is a member of a law firm which provides services to SunLink. The Company has expensed an aggregate of $306 and $229 to the law firm in the fiscal years ended June 30, 2019 and 2018, respectively. Included in the Company's consolidated balance sheets at June 30, 2019 and 2018 is $47 and $10 of amounts payable to the law firm.

On June 5, 2018, the Company purchased 70,000 common shares for $1.40 per share, or $98 in total, from a director of the Company at a price equal to the closing price on the date of the Company's common shares on the NYSE American Exchange. This purchase was approved on June 1, 2018 by the Executive Committee of the Company' Board of Directors.

18. SUBSEQUENT EVENTS

Sale of property — On September 9, 2019, the Company sold approximately 11.4 acres of undeveloped land. After expenses, the Company received net proceeds from the sale of $348, which is being retained for working capital needs and general corporate purposes. The pre-tax gain on the sale is approximately $100 which will be included in the results for the fiscal quarter ended September 30, 2019.

Stock option issuance — On September 9, 2019, a total of options for 50,000 shares were issued by the Company to non-employee directors (10,000 to each) at a price of $1.38 per share from the 2011 Director Stock Option Plan.

Stock option forfeiture — On September 9, 2019, 165,000 unexpired stock options issued under the 2005 Equity Incentive Plan with exercise prices $1.79 and $2.09 were forfeited by two employees.

19. FINANCIAL INFORMATION BY SEGMENTS

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

We evaluate performance of our operating segments based on revenue and operating profit (loss). Segment information for the fiscal years ended June 30, 2019 and 2018 is as follows:

	Healthcare Services	Pharmacy	Corporate and Other	Total
2019				
Net Revenues from external customers	$ 15,453	$ 30,165	$ 0	$ 45,618
Operating loss	(538)	147	(1,923)	(2,314)
Depreciation and amortization	336	1,147	3	1,486
Assets	7,612	8,273	8,534	24,419
Expenditures for property, plant and equipment	309	961	2	1,272
2018				
Net Revenues from external customers	$ 15,745	$ 29,464	$ 0	$ 45,209
Operating loss	687	(119)	(1,680)	(1,112)
Depreciation and amortization	339	1,189	3	1,531
Assets	13,991	7,937	4,248	26,176
Expenditures for property, plant and equipment	318	814	0	1,132

19. EARNINGS PER SHARE

(Share Amounts in Thousands)

Earnings (loss) per share and shares outstanding information for the years ended June 30, 2019 and 2018 is as follows:

	2019		2018	
	Amount	Per Share Amount	Amount	Per Share Amount
Loss from continuing operations	$ (1,996)		$ (226)	
Basic:				
Weighted-average shares outstanding	7,149	$ (0.28)	8,283	$ (0.03)
Diluted:				
Weighted-average shares outstanding	7,149	$ (0.28)	8,283	$ (0.03)
Earnings (loss) from discontinued operations	$ 242		$ (1,367)	
Basic:				
Weighted-average shares outstanding	7,149	$ 0.03	8,283	$ (0.17)
Diluted:				
Weighted-average shares outstanding	7,149	$ 0.03	8,283	$ (0.17)
Net Loss	$ (1,754)		$ (1,593)	
Basic:				
Weighted-average shares outstanding	7,149	$ (0.25)	8,283	$ (0.19)
Diluted:				
Weighted-average shares outstanding	7,149	$ (0.25)	8,283	$ (0.19)
Weighted-average number of shares outstanding—basic	7,149		8,283	
Effect of dilutive director, employee and guarantor options and outstanding common share warrants	0		0	
Weighted-average number of shares outstanding—diluted	7,149		8,283	

Share options of 31 and 61 for the years ended June 30, 2019 and 2018 are not included in the computation of diluted earnings per share because their effect would be antidilutive.

Shareholder Information

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TRANSFER AGENT AND REGISTRAR
American Stock Transfer
Attn: Shareholder Services
10150 Mallard Creek Road, Suite 307
Charlotte, NC 28262
1-866-668-6550

STOCK EXCHANGE LISTING
The Company's common shares are traded on the NYSE American exchange under the symbol **SSY.**

ANNUAL MEETING
The Annual Meeting of Shareholders
Will be held Monday,
November 11, 2019
At 10:00 a.m. local time at
Hyatt House Hotel
3595 Cumberland Blvd. SE
Atlanta, GA 30339

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