Consolidated Financial Statements, Supplementary Information and OMB Circular A-133 Reports and Schedules

Sacred Heart Health System, Inc. and Subsidiaries –
Member of Ascension Health, a Subsidiary of Ascension Health Alliance
Years Ended June 30, 2012 and 2011
With Report of Independent Auditors

Ernst & Young LLP

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Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Financial Statements, Supplementary Information and OMB Circular A-133 Reports and Schedules

Years Ended June 30, 2012 and 2011

Contents

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Report of Independent Auditors

The Board of Directors
Sacred Heart Health System, Inc. and Subsidiaries

We have audited the accompanying consolidated balance sheets of Sacred Heart Health System, Inc. and Subsidiaries (Sacred Heart Health System) as of June 30, 2012 and 2011, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of Sacred Heart Health System's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of Sacred Heart Health System's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Sacred Heart Health System's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Sacred Heart Health System as of June 30, 2012 and 2011, and the consolidated results of their operations and changes in net assets, and cash flows for the years then ended in conformity with US generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we have also issued our report dated September 12, 2012 on our consideration of Sacred Heart Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Ernst & Young LLP

September 12, 2012

Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Balance Sheets

(In Thousands)

	June 30	
	2012	**2011**
Assets		
Current assets:		
Cash and cash equivalents	**$ 13,275**	$ 42,038
Interest in investments held by Ascension Health Alliance	**16,165**	–
Accounts receivable, less allowances for uncollectible accounts ($71,995 and $47,074 in 2012 and 2011, respectively)	**103,179**	88,691
Current portion of assets limited as to use	**2,641**	1,167
Estimated third-party payor settlements	**21,618**	22,235
Inventories	**15,777**	14,939
Assets held for sale	**2,050**	2,174
Other	**12,996**	8,952
Total current assets	**187,701**	180,196
Assets limited as to use and other long-term investments	**10,963**	11,316
Interest in investments held by Ascension Health Alliance	**170,047**	–
Property and equipment, net	**284,446**	282,482
Other assets:		
Land held for expansion	**4,702**	4,702
Investment in unconsolidated entities	**38,637**	7,852
Other investments	**–**	201,501
Other	**19,524**	19,607
Total other assets	**62,863**	233,662
Total assets	**$ 716,020**	$ 707,656

See accompanying notes.

	June 30	
	2012	**2011**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 1,158**	$ 1,087
Accounts payable and accrued liabilities	**55,019**	60,562
Estimated third-party payor settlements	**7,299**	15,548
Current portion of self-insurance liabilities	**1,003**	1,526
Intercompany accounts payable	**6,502**	–
Total current liabilities	**70,981**	78,723
Noncurrent liabilities:		
Long-term debt	**125,734**	126,908
Self-insurance liabilities	**2,686**	2,701
Pension liabilities	**16,704**	16,610
Other	**30,276**	29,184
Total noncurrent liabilities	**175,400**	175,403
Total liabilities	**246,381**	254,126
Net assets:		
Unrestricted:		
Controlling interest	**457,514**	442,494
Noncontrolling interests	**2,033**	2,009
Unrestricted net assets	**459,547**	444,503
Temporarily restricted – controlling interest	**10,092**	9,027
Total net assets	**469,639**	453,530
Total liabilities and net assets	**$ 716,020**	$ 707,656

See accompanying notes.

Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets

(In Thousands)

	Year Ended June 30	
	2012	2011
Operating revenue:		
Net patient service revenue	**$ 737,983**	$ 726,932
Other revenue	**19,588**	12,526
(Loss) income from unconsolidated entities	**(978)**	1,001
Net assets released from restrictions for operations	**697**	1,292
Total operating revenue	**757,290**	741,751
Operating expenses:		
Salaries and wages	**263,074**	248,819
Employee benefits	**59,521**	63,690
Purchased services	**48,745**	37,773
Professional fees	**33,248**	29,091
Supplies	**130,985**	128,441
Insurance	**3,098**	5,685
Bad debts	**84,457**	78,026
Interest	**6,048**	6,201
Depreciation and amortization	**29,096**	30,255
Other	**72,164**	83,826
Total operating expenses before impairment, restructuring, and nonrecurring gains, net	**730,436**	711,807
Income from operations before impairment, restructuring, and nonrecurring gains, net	**26,854**	29,944
Impairment, restructuring, and nonrecurring gains (losses), net	**19,558**	(677)
Income from operations	**46,412**	29,267
Nonoperating (losses) gains:		
Investment return	**(2,107)**	30,773
Other	**(701)**	(346)
Total nonoperating (losses) gains, net	**(2,808)**	30,427
Excess of revenues and gains over expenses and losses	**43,604**	59,694
Less excess of revenue and gains over expenses and losses attributable to noncontrolling interests	**(2,834)**	(1,968)
Excess of revenues and gains over expenses and losses attributable to controlling interest	**40,770**	57,726

Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Statements of Operations and Changes in Net Assets (continued)

(In Thousands)

	Year Ended June 30	
	2012	**2011**
Unrestricted net assets:		
Excess of revenues and gains over expenses and losses	**$ 40,770**	$ 57,726
Pension and other postretirement liability adjustments	**(18,779)**	25,505
Transfers to sponsor and other affiliates, net	**(8,378)**	(12,191)
Net assets released from restrictions for property acquisitions	**1,499**	1,703
Other	**(90)**	(2,012)
Increase in unrestricted net assets, controlling interest, before cumulative effect of change in accounting principle	**15,022**	70,731
Cumulative effect of change in accounting principle	**–**	(4,563)
Increase in unrestricted net assets, controlling interest	**15,022**	66,168
Unrestricted net assets, noncontrolling interest:		
Excess of revenues and gains over expenses and losses	**24**	1,968
Increase in unrestricted net assets, noncontrolling interest	**24**	1,968
Temporarily restricted net assets:		
Contributions and grants	**3,258**	2,212
Net assets released from restrictions	**(2,195)**	(2,994)
Other	**–**	4
Increase (decrease) in temporarily restricted net assets	**1,063**	(778)
Increase in net assets	**16,109**	67,358
Net assets at beginning of year	**453,530**	386,172
Net assets at end of year	**$ 469,639**	$ 453,530

See accompanying notes.

Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows
(In Thousands)

	Year Ended June 30	
	2012	**2011**
Operating activities		
Increase in net assets	**$ 16,109**	$ 67,358
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	**29,096**	30,255
Provision for bad debts	**84,457**	78,026
Loss (income) from unconsolidated entities	**978**	(1,001)
Interest, dividends, and net losses (gains) on investments	**2,107**	(14,343)
Impairment and nonrecurring (income) expenses	**(19,558)**	677
Cumulative effect of changes in accounting principles	**–**	4,563
Transfers to sponsor and other affiliates, net	**8,378**	12,191
Restricted contributions, investment return and other	**(1,499)**	(1,703)
(Increase) decrease in:		
Interest in investments held by Ascension Health Alliance	**12,753**	–
Accounts receivable	**(98,944)**	(91,143)
Estimated third-party payor settlements receivable, net	**(7,632)**	(6,157)
Inventories and other current assets	**(6,772)**	490
Investments classified as trading	**–**	(25,266)
Other noncurrent assets	**4,307**	(10,282)
Increase (decrease) in:		
Accounts payable and accrued liabilities	**(5,543)**	6,400
Intercompany accounts payable	**6,502**	–
Self-Insurance liabilities	**(538)**	–
Other noncurrent liabilities	**21,283**	(19,241)
Net cash provided by operating activities	**45,484**	30,824

Sacred Heart Health System, Inc. and Subsidiaries

Consolidated Statements of Cash Flows (continued)
(In Thousands)

	Year Ended June 30	
	2012	**2011**
Investing activities		
Property, equipment, and capitalized software additions, net	**$ (33,943)**	$ (12,837)
Increase in asset limited as to use – temporary restricted	**–**	(1,156)
Investment in unconsolidated entities	**(32,322)**	–
Net cash used in investing activities	**(66,265)**	(13,993)
Financing activities		
Issuance of long-term debt		
Repayment of long-term debt	**(1,103)**	(1,227)
Transfers to sponsors and other affiliates, net	**(8,378)**	(12,191)
Restricted contributions, investment income and other	**1,499**	1,703
Net cash used in financing activities	**(7,982)**	(11,715)
Net decrease in cash and cash equivalents	**(28,763)**	5,116
Cash and cash equivalents at beginning of year	**42,038**	36,922
Cash and cash equivalents at end of year	**$ 13,275**	$ 42,038

See accompanying notes.

1. Organization and Mission

Organizational Structure

Sacred Heart Health System, Inc. and Subsidiaries (the Health Ministry) is a member of Ascension Health. In December 2011, Ascension Health Alliance became the sole corporate member and parent organization of Ascension Health, a Catholic national health system consisting primarily of nonprofit corporations that own and operate local health care facilities, or Health Ministries, located in 21 of the United States and the District of Columbia. In addition to serving as the sole corporate member of Ascension Health, Ascension Health Alliance serves as the member or shareholder of various other subsidiaries. Ascension Health Alliance, its subsidiaries, and the Health Ministries are referred to collectively from time to time hereafter as the System.

Ascension Health Alliance is sponsored by Ascension Health Ministries, a Public Juridic Person. The Participating Entities of Ascension Health Ministries are the Daughters of Charity of St. Vincent de Paul in the United States, St. Louise Province, the Congregation of St. Joseph, the Congregation of the Sisters of St. Joseph of Carondelet, and the Congregation of Alexian Brothers of the Immaculate Conception Province – American Province.

The System's principal operations consist of three nonprofit acute care hospitals: Sacred Heart Hospital (located in Pensacola, Florida), Sacred Heart Hospital on the Emerald Coast (located in Destin, Florida), and Sacred Heart Hospital on the Gulf (located in Port St. Joe, Florida). The System also owns and operates other health care-related entities, including a nursing facility and physicians' medical group. The System provides inpatient, outpatient, and emergency care services for residents of northwest Florida. Admitting physicians are primarily practitioners in the local area. The System is related to Ascension Health's other sponsored organizations through common control. Substantially all expenses of Ascension Health are related to providing health care services.

1. Organization and Mission (continued)

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Health Ministries united in service and healing and dedicates its resources to spiritually centered care that sustains and improves the health of the individuals and communities it serves. In accordance with the System's mission of service to those persons living in poverty and other vulnerable persons, each Health Ministry accepts patients regardless of their ability to pay. The System uses four categories to identify the resources utilized for the care of persons living in poverty and community benefit programs:

- Traditional charity care includes the cost of services provided to persons who cannot afford health care because of inadequate resources and/or who are uninsured or underinsured.

- Unpaid cost of public programs, excluding Medicare, represents the unpaid cost of services provided to persons covered by public programs for persons living in poverty and other vulnerable persons.

- Cost of other programs for persons living in poverty and other vulnerable persons includes unreimbursed costs of programs intentionally designed to serve the persons living in poverty and other vulnerable persons of the community, including substance abusers, the homeless, victims of child abuse, and persons with acquired immune deficiency syndrome.

- Community benefit consists of the unreimbursed costs of community benefit programs and services for the general community, not solely for the persons living in poverty, including health promotion and education, health clinics and screenings, and medical research.

Discounts are provided to all uninsured patients, including those with the means to pay. Discounts provided to those patients who did not qualify for assistance under charity care guidelines are not included in the cost of providing care of persons living in poverty and community benefit programs. The cost of providing care of persons living in poverty and community benefit programs is estimated using internal cost data and is calculated in compliance with guidelines established by both the Catholic Health Association and the Internal Revenue Service.

(Dollars in Thousands)

1. Organization and Mission (continued)

The amount of traditional charity care provided, determined on the basis of cost, excluding the provision for bad debt expense, was approximately $17,414 and $16,816 for the years ended June 30, 2012 and 2011, respectively. The amount of unpaid cost of public programs, cost of other programs for persons living in poverty and other vulnerable persons, and community benefit cost are reported in the accompanying supplementary information.

2. Significant Accounting Policies

Principles of Consolidation

All corporations and other entities for which operating control is exercised by the Health Ministry or one of its member corporations are consolidated, and all significant inter-entity transactions have been eliminated in consolidation.

Investments in entities where the Health Ministry does not have operating control are recorded under the equity or cost method of accounting. For entities recorded under the equity method of accounting, the following reflects the Health Ministry's interest in unconsolidated entities in the consolidated balance sheets, as well as income or loss for such entities included in the consolidated excess of revenues and gains over expenses and losses in the accompanying consolidated statements of operations and changes in net assets:

	Investment Recorded in Consolidated Balance Sheets June 30		**Effect on Consolidated Excess of Revenues and Gains Over Expenses and Losses Years Ended June 30**	
	2012	**2011**	**2012**	**2011**
Pace Ambulatory Surgery Center, LLC	**$ –**	$ –	**$ –**	$ 452
Destin Ambulatory Surgical Center, LLC	**361**	391	**156**	144
Escambia Clinics Holdings, Inc.	**475**	477	**(2)**	(1)
Gulf Region Radiation Oncology, LLC	**6,214**	6,984	**(401)**	405
Bay County Health System, LLC	**31,587**	–	**(735)**	–
	$ 38,637	$ 7,852	**$ (982)**	$ 1,000

2. Significant Accounting Policies (continued)

The Health Ministry's equity in the income (loss) of unconsolidated entities is recorded in other operating revenue if the investment relates to providing health care services and is recorded in other nonoperating gains (losses) if the investment relates to activities not related to providing health care services. The Health Ministry recorded $978 in operating loss for the year ended June 30, 2012, and $1,001 in other operating revenue for the year ended June 30, 2011. The Health Ministry recorded $2 and $1 in other nonoperating losses for the years ended June 30, 2012 and 2011, respectively.

The Health Ministry's equity investment in Gulf Region Radiation Oncology MSO, LLC (GRROC) does not equate to the Health Ministry's 51% ownership of GRROC's equity balance due to a difference in the cost basis and the fair market value of assets contributed. In accordance with Accounting Standards Codification (ASC) Topic 323, *Investments – Equity Method and Joint Ventures*, this basis difference is being amortized over the weighted average life of the assets contributed, net of the Health Ministry's earnings in the investment.

Use of Estimates

Management has made estimates and assumptions that affect the reported amounts of certain assets, liabilities, revenues, and expenses. Actual results could differ from those estimates.

Fair Value of Financial Instruments

The carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of financial instruments classified as other than current assets and current liabilities are disclosed in Note 4.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with maturities of three months or less.

2. Significant Accounting Policies (continued)

Interest in Investments Held by Ascension Health Alliance, Investments and Investment Return

At June 30, 2011, and prior to April 2012, the Health Ministry held a significant portion of its investments through the Health System Depository (HSD), an investment pool of funds in which the System and a limited number of nonprofit health care providers participated. The HSD investments were managed primarily by external investment managers within established investment guidelines. The value of the Health Ministry's investment in the HSD represented the Health Ministry's pro rata share of the HSD's funds held for participants. At June 30, 2011, the Health Ministry's investment in the HSD was $222,369, reflected in cash and cash equivalents, assets limited as to use, and other long-term investments in the consolidated balance sheet.

During the year ended June 30, 2012, the CHIMCO Alpha Fund, LLC (Alpha Fund) was created to hold primarily all investments previously held through the HSD. Catholic Healthcare Investment Management Company (CHIMCO), a wholly owned subsidiary of Ascension Health Alliance, acts as manager and serves as the principal investment advisor for the Alpha Fund within established investment guidelines, including socially responsible investment guidelines. In April 2012, a significant portion of the HSD's funds held for participants was transferred to the Alpha Fund, in which Ascension Health Alliance has an investment interest, as a member of the Alpha Fund. Ascension Health Alliance invests funds in the Alpha Fund on behalf of the Health Ministry. As of June 30, 2012, the Health Ministry has an interest in investments held by Ascension Health Alliance, which is reflected in the consolidated balance sheet, and represents the Health Ministry's pro rata share of Ascension Health Alliance's investment interest in the Alpha Fund.

The Health Ministry also invests primarily in private equities that are locally managed. Primarily all of these funds are held in the Sacred Heart Foundation, where the Health Ministry has significant beneficial interest in foundation assets.

The Health Ministry reports its interest in investments held by Ascension Health Alliance in the accompanying June 30, 2012 consolidated balance sheet as a current or long-term asset, based on liquidity needs as directed by the Health Ministry. The Health Ministry reports its other investments, including foundation investments, in the accompanying consolidated balance sheets based upon the long- or short-term nature of the investments and whether such investments are restricted by law or donors or designated for specific purposes by a governing body of Health Ministry.

2. Significant Accounting Policies (continued)

The Health Ministry's investments, excluding its interest in investments held by Ascension Health Alliance, are measured at fair value and are classified as trading securities. The Alpha Fund's and the HSD's investments that are required to be recorded at fair value are classified as trading securities, and include pooled short-term investment funds; U.S. government, state, municipal, and agency obligations; asset-backed securities; corporate and foreign fixed income maturities; and equity securities, including private equity securities. The Alpha Fund's and HSD's investments also include alternative investments, including investments in real assets, hedge funds, private equity funds, commodity funds, and private credit funds, which are valued based on the net asset value of the investments. In addition, the Alpha Fund participates, and the HSD participated, in securities lending transactions whereby a portion of the investments are loaned to selected established brokerage firms in return for cash and securities from the brokers as collateral for the investments loaned.

Purchases and sales of investments are accounted for on a trade-date basis. Investment returns comprise dividends, interest, and gains and losses on the Health Ministry's investments, as well as the Health Ministry's return on its interest in investments held by Ascension Health Alliance, and are reported as nonoperating gains (losses) in the consolidated statements of operations and changes in net assets, unless the return is restricted by donor or law.

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market value utilizing first-in, first-out (FIFO), or a methodology that closely approximates FIFO.

Deferred Compensation

Certain executives of the Health Ministry participate in a deferred compensation plan. Total cost for the plans in 2012 and 2011 was $521 and $390, respectively. The plan assets are recorded at fair value with an offsetting noncurrent liability, included in other noncurrent liabilities on the consolidated balance sheet, equal to the assets.

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

Intangible Assets

Intangible assets primarily consist of goodwill and capitalized computer software costs, including software internally developed. Costs incurred in the development and installation of internal-use software are expensed or capitalized depending on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage. Intangible assets are included in other noncurrent assets on the consolidated balance sheets and comprise the following:

	June 30	
	2012	**2011**
Capitalized computer software costs	**$ 25,855**	$ 22,972
Less: accumulated amortization	**(20,135)**	(18,592)
Total intangible assets, net	**$ 5,720**	$ 4,380

Intangible assets with definite lives, primarily capitalized computer software costs, are amortized over their expected useful lives.

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date of the gift. A summary of property and equipment at June 30, 2012 and 2011, is as follows:

	June 30	
	2012	**2011**
Land and improvements	**$ 49,815**	$ 49,815
Building and equipment	**545,759**	528,987
	595,574	578,802
Less accumulated depreciation	**(329,439)**	(303,034)
	266,135	275,768
Construction in progress	**18,311**	6,714
Total property and equipment, net	**$ 284,446**	$ 282,482

2. Significant Accounting Policies (continued)

Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Depreciation expense in 2012 and 2011 was $27,218 and $27,628, respectively.

Estimated useful lives by asset category are as follows: land improvements – 5 to 15 years; buildings – 5 to 30 years; and equipment – 5 to 15 years.

Several capital projects have remaining construction and related equipment purchase commitments of approximately $10,597 as of June 30, 2012.

Noncontrolling Interest

The consolidated financial statements include all assets, liabilities, revenue, and expenses of less than 100% owned or controlled entities the Health Ministry controls in accordance with applicable accounting guidance. Accordingly, the Health Ministry has reflected a noncontrolling interest for the portion of net assets not owned or controlled by the Health Ministry separately on the consolidated balance sheets.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the Health Ministry has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, which include endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donor's wishes, primarily to purchase equipment and to provide charity care and other health and educational services. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as unrestricted.

Performance Indicator

The performance indicator is excess of revenues and gains over expenses and losses. Changes in unrestricted net assets that are excluded from the performance indicator primarily include pension and other postretirement liability adjustments, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, and contributions of property and equipment.

2. Significant Accounting Policies (continued)

Operating and Nonoperating Activities

The Health Ministry's primary mission is to meet the health care needs in its market area through a broad range of general and specialized health care services, including inpatient acute care, outpatient services, long-term care, and other health care services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the Health Ministry's primary mission are considered to be nonoperating, consisting primarily of investment income.

Net Patient Service Revenue, Accounts Receivable, and Allowance for Uncollectible Accounts

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services provided, excluding the provision for bad debt expense, and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates will change by a material amount in the near term. Adjustments to revenue related to prior periods increased net patient service revenue by approximately $9,036 and $6,899 for the years ended June 30, 2012 and 2011, respectively.

During 2012, approximately 33% of net patient service revenue was received under the Medicare program and 12% under various state Medicaid programs. During 2011, approximately 31% of net patient service revenue was received under the Medicare program and 13% under various state Medicaid programs. The Health Ministry grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor arrangements. Significant concentrations of net accounts receivable at June 30, 2012, include Medicare (18%) and various states' Medicaid programs (19%). Significant concentrations of net accounts receivable at June 30, 2011, include Medicare (15 %) and various states' Medicaid programs (12%).

2. Significant Accounting Policies (continued)

The provision for bad debt expense is based upon management's assessment of expected net collections considering economic conditions, historical experience, trends in health care coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for uncollectible accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for bad debt expense to establish an appropriate allowance for uncollectible accounts. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the Health Ministry follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by Ascension Health. Accounts receivable are written off after collection efforts have been followed in accordance with the Health Ministry's policies.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 (ARRA) included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

The Health Ministry accounts for HITECH incentive payments as a gain contingency. Income from Medicare incentive payments is recognized as revenue after the Health Ministry has demonstrated that it complied with the meaningful use criteria over the entire applicable compliance period and the cost report period that will be used to determine the final incentive payment has ended. The Health Ministry recognized revenue from Medicaid incentive payments after it adopted certified HER technology. Incentive payments totaling $3,020 for the year ended

2. Significant Accounting Policies (continued)

June 30, 2012, are included in total operating revenue in the accompanying consolidated statements of operations and changes in net assets. Income from incentive payments is subject to retrospective adjustment as the incentive payments are calculated using Medicare cost report data that is subject to audit. In addition, the Health Ministry's compliance with the meaningful use criteria is subject to audit by the federal government.

Impairment, Restructuring, and Nonrecurring Expenses

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on discounted net cash flows or other estimates of fair value.

During the years ended June 30, 2012 and 2011, the Health Ministry recorded total impairment, restructuring, and nonrecurring income of $19,558 and nonrecurring expense of $677, respectively. The restructuring and nonrecurring expense for the year ended June 30, 2012, included approximately $540 in expense related to the termination of an information technology service contract and a pension curtailment gain of $20,098 discussed further in Note 6. For the year ended June 30, 2011, total impairment, restructuring, and nonrecurring expenses of $677 comprised approximately $538 of restructuring and nonrecurring expenses related to changes in business operations, including reorganization and severance charges as well as approximately $139 of long-lived asset impairments.

Hospital or Health Ministry Income Taxes

The member health care entities of the Health Ministry are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) or 501(c)(2), and their related income is exempt from federal income tax under Section 501(a).

Reclassifications

Certain reclassifications were made to the 2011 consolidated financial statements to conform to the 2012 presentation.

2. Significant Accounting Policies (continued)

Subsequent Events

The Health Ministry evaluates the impact of subsequent events, which are events that occur after the balance sheet date but before the financial statements are issued, for potential recognition in the financial statements as of the balance sheet date. For the year ended June 30, 2012, the Health Ministry evaluated subsequent events through September 12, 2012, representing the date on which the consolidated financial statements were available to be issued. During this period, there were no subsequent events that required recognition or disclosure in the consolidated financial statements. In addition, there were no nonrecognized subsequent events that required disclosure.

Adoption of New Accounting Standards

In January 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-06, *Improving Disclosures about Fair Value Measurements*. ASU 2010-06 clarifies certain fair value measurement guidance and requires that additional fair value measurement disclosures be made. The Health Ministry adopted a portion of this guidance during the fiscal year ended June 30, 2010, and the remaining requirements as of July 1, 2011, as required. The disclosure updates adopted as of July 1, 2011, result in the provision of additional detail within the reconciliation of beginning and ending balances for assets and liabilities measured at fair value, whose fair value inputs are based on significant unobservable inputs (i.e., Level 3 assets and liabilities). These additional disclosure requirements are provided in Note 4. The adoption of this guidance did not have a material impact on the Health Ministry's consolidated financial statements for the year ended June 30, 2012.

In August 2010, the FASB issued ASU 2010-23, *Measuring Charity Care for Disclosure*. ASU 2010-23 requires health care entities to disclose charity care based on cost measurements, defined as the direct and indirect costs of providing the charity care. The Health Ministry adopted this guidance on July 1, 2011; however, as the Health Ministry has historically used cost-based measures for the calculation and disclosure of its charity care, the adoption of this guidance did not have a material impact on the Health Ministry's consolidated financial statements for the year ended June 30, 2012.

2. Significant Accounting Policies (continued)

In May 2011, the FASB issued ASU 2011-04, *Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. Generally Accepted Accounting Principles (GAAP) and International Financial Reporting Standards (IFRS)*. ASU 2011-04 provides clarifications to certain existing fair value measurement guidance and includes updated guidance for certain fair value measurement principles and disclosures. The Health Ministry adopted this guidance as of January 1, 2012. The adoption of this guidance did not have a material impact on the Health Ministry's consolidated financial statements for the year ended June 30, 2012.

In July 2011, the FASB issued ASU 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debt and the Allowance for Doubtful Accounts for Certain Health Care Entities*. ASU 2011-07 requires health care entities that recognize significant amounts of patient service revenue at the time services are rendered to present the provision for bad debts related to patient service revenue as a deduction from patient service revenue in the statement of operations rather than as operating expense. Additional disclosures relating to sources of patient service revenue and the allowance for uncollectible accounts are also required. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011, with early adoption permitted. The Health Ministry plans to adopt the provisions of ASU 2011-07 as of and for the year ended June 30, 2013, and retrospectively apply the presentation requirements to all periods presented.

(Dollars in Thousands)

3. Cash and Cash Equivalents, Interest in Investments Held by Ascension Health Alliance, and Assets Limited as to Use and Other Long-Term Investments

At June 30, 2012, the Health Ministry's investments consist of its interest in investments held by Ascension Health Alliance and certain other investments, including investments held and managed by the Sacred Heart Foundation. At June 30, 2011, the Health Ministry's investments consisted of the Health Ministry's pro rata share of the HSD's funds held for participants and certain other investments, including investments held and managed by the Sacred Heart Foundation. Board-designated investments represent investments designated by resolution of the Sacred Heart Foundation Board to put amounts aside primarily for future capital expansion and improvements. Assets limited as to use primarily include investments restricted by donors. The Health Ministry's cash, cash equivalents, interest in investments held by Ascension Health Alliance, and assets limited as to use and other long-term investments are reported in the accompanying consolidated balance sheets as presented in the following table:

	June 30	
	2012	**2011**
Cash and cash equivalents	**$ 13,275**	$ 42,038
Current portion of assets limited as to use	**2,641**	1,167
Assets limited as to use and other long-term investments:		
Assets limited as to use	**3,514**	3,457
Other long-term investments	**7,449**	7,859
Total assets limited as to use, and other long-term investments	**10,963**	11,316
Other investments	**–**	201,501
Other noncurrent assets	**11,106**	11,669
Interest in investments held by Ascension Health Alliance	**186,212**	–
Total	**$ 224,197**	$ 267,691

(Dollars in Thousands)

3. Cash and Cash Equivalents, Interest in Investments Held by Ascension Health Alliance, and Assets Limited as to Use and Other Long-Term Investments (continued)

The composition of cash and investments classified as cash and cash equivalents, board-designated investments, assets limited as to use, and other investments is summarized as follows:

	June 30	
	2012	**2011**
Cash and cash equivalents	**$ 13,275**	$ 42,038
Assets limited as to use:		
Cash and current portion of pledges receivable	**2,641**	1,167
Noncurrent portion of pledges receivable, net	**2,088**	4,787
Long-term investments at fair value	**8,875**	6,529
Current portion of assets limited as to use, noncurrent portion of assets limited as to use, and other long-term investments	**13,604**	12,483
Interest in investments held by Ascension Health Alliance	**186,212**	–
Pro rata share of HSD funds held for participants	**–**	201,501
Other noncurrent assets (deferred compensation assets)	**11,106**	11,669
Cash and cash equivalents, short-term investments, interest in investments held by Ascension Health Alliance, assets limited as to use and other long-term investments	**$ 224,197**	$ 267,691

(Dollars in Thousands)

3. Cash and Cash Equivalents, Interest in Investments Held by Ascension Health Alliance, and Assets Limited as to Use and Other Long-Term Investments (continued)

As of June 30, 2012 and 2011, the composition of total Alpha Fund and HSD investments is as follows:

	June 30	
	2012	**2011**
Cash, cash equivalents and short-term investments	**4.7%**	6.9%
U.S. government obligations	**32.1**	27.4
Asset-backed securities	**10.3**	15.8
Corporate and foreign fixed income investments	**9.0**	11.3
Equity, private equity, and other investments	**43.9**	38.6
Total	**100.0%**	100.0%

Investment return recognized by the Health Ministry is summarized as follows:

	Year Ended June 30	
	2012	**2011**
Return on interest in investments held by Ascension Health Alliance and investment return in HSD	**$ 9,839**	$ 16,430
Net (losses) gains on investments reported at fair value	**(11,946)**	14,303
Total investment return included in nonoperating (losses) gains	**$ (2,107)**	$ 30,733

4. Fair Value Measurements

The Health Ministry categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available in the circumstances.

4. Fair Value Measurements (continued)

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The Health Ministry's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The Health Ministry follows the three-level fair value hierarchy to categorize these assets and liabilities recognized at fair value at each reporting period, which prioritizes the inputs used to measure such fair values. Level inputs are defined as follows:

> Level 1 – Quoted prices (unadjusted) that are readily available in active markets or exchanges for identical assets or liabilities on the reporting date.
>
> Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 pricing inputs include prices quoted for similar investments in active markets or exchanges or prices quote for identical or similar investments in markets that are not active. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.
>
> Level 3 – Significant pricing inputs that are unobservable for the asset or liability, including assets or liabilities for which there is little, if any, market activity for such asset or liability. Inputs to the determination of fair value for Level 3 assets and liabilities require management judgment and estimation.

As of June 30, 2012 and 2011, assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

Equity securities

The fair value of U.S. and international equity securities is valued at the closing quoted price on the active market for which the individual securities are traded.

4. Fair Value Measurements (continued)

Corporate and foreign fixed income maturities

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

Guaranteed pooled fund

The fair value of guaranteed pooled fund investments is based on cost plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying the annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

As discussed in Note 2 and Note 3, the Health Ministry has an interest in investments held by Ascension Health Alliance. As of June 30, 2012**,** 17%, 52%, and 31% of total Alpha Fund assets that are measured at fair value on a recurring basis were measured based on Level 1, Level 2, and Level 3 inputs, respectively, while 0%, 100%, and 0% of total Alpha Fund liabilities that are measured at fair value on a recurring basis were measured at such fair values based on Level 1, Level 2, and Level 3 inputs, respectively. As of June 30, 2011, 31%, 67%, and 2% of total HSD assets that were measured at fair value on a recurring basis were measured based on Level 1, Level 2, and Level 3 inputs, respectively, while 1%, 84%, and 15% of total HSD liabilities that were measured at fair value on a recurring basis were measured based on Level 1, Level 2, and Level 3 inputs, respectively.

(Dollars in Thousands)

4. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2012, for all other financial assets and liabilities that are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2012				
Assets limited as to use and other long-term investments:				
Equity securities	**$ 7,461**	**$ –**	**$ –**	**$ 7,461**
Corporate bonds	**–**	**1,413**	**–**	**1,413**
Deferred compensation assets, included in other noncurrent assets:				
Equity securities	**7,046**	**–**	**–**	**7,046**
Guaranteed pooled fund	**–**	**–**	**4,060**	**4,060**
Total	**$ 14,507**	**$ 1,413**	**$ 4,060**	**$ 19,980**

The following table summarizes fair value measurements, by level, at June 30, 2011, for all other financial assets and liabilities, measured at fair value on a recurring basis in the Health Ministry's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2011				
Assets limited as to use and other long-term investments:				
Equity securities	$ 5,797	$ –	$ –	$ 5,797
Corporate bonds	–	732	–	732
Deferred compensation assets, included in other noncurrent assets:				
Equity securities	7,224	–	–	7,224
Guaranteed pooled fund	–	–	4,445	4,445
Total	$ 13,021	$ 732	$ 4,445	$ 18,198

(Dollars in Thousands)

4. Fair Value Measurements (continued)

During the years ended June 30, 2012 and 2011, the changes in the fair value of the foregoing assets measured using significant unobservable inputs (Level 3) comprised the following.

	Deferred Compensation Assets
July 1, 2010	$ 2,740
Purchases, issuances and settlements	1,336
Transfers into Level 3	369
June 30, 2011	4,445
Purchases	**360**
Sales	**(601)**
Transfers into Level 3	**37**
Transfers out of Level 3	**(181)**
June 30, 2012	**$ 4,060**

5. Long-Term Debt

Long-term debt consists of the following:

	June 30 2012	2011
Intercompany debt with Ascension Health Alliance, payable in installments through 2047; interest (3.8% and 3.9% at June 30, 2012 and 2011, respectively) adjusted based on prevailing blended market interest rate of underlying debt obligations	**$ 125,879**	$ 126,792
Other	**1,013**	1,203
	126,892	127,995
Less current portion	**(1,158)**	(1,087)
Long-term debt, less current portion	**$ 125,734**	$ 126,908

(Dollars in Thousands)

5. Long-Term Debt (continued)

Scheduled principal repayments of long-term debt are as follows:

Year ending June 30:		
2013	$	1,158
2014		2,032
2015		2,588
2016		1,602
2017		1,975
Thereafter		117,537
Total	$	126,892

Certain members of Ascension Health Alliance formed the Ascension Health Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member, senior designated affiliate, or senior limited designated affiliate. Senior obligated group members are jointly and severally liable under a Senior Master Trust Indenture (Senior MTI) to make all payments required with respect to obligations under the Senior MTI and may be entities not controlled directly or indirectly by Ascension Health Alliance. Although senior designated affiliates and senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI, Ascension Health Alliance may cause each senior designated affiliate to transfer such amounts as are necessary to enable the obligated group to comply with the terms of the Senior MTI, including repayment of the outstanding obligations. In addition, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with Ascension Health Alliance with stipulated repayment terms and conditions, each subject to the governing law of the senior limited designated affiliate's state of incorporation. The Health Ministry is a senior obligated group member under the terms of the Senior MTI.

Pursuant to a Supplemental Master Indenture dated February 1, 2005, senior obligated group members, which are operating entities, have pledged and assigned to the Master Trustee a security interest in all of their rights, title, and interest in their pledged revenues and proceeds thereof.

5. Long-Term Debt (continued)

A Subordinate Credit Group, which comprises subordinate obligated group members, subordinate designated affiliates, and subordinate limited designated affiliates, was created under the Subordinate Master Trust Indenture (Subordinate MTI). The subordinate obligated group members are jointly and severally liable under the Subordinate MTI to make all payments required with respect to obligations under the Subordinate MTI and may be entities not controlled directly or indirectly by Ascension Health Alliance. Although subordinate designated affiliates and subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI, Ascension Health Alliance may cause each subordinate designated affiliate to transfer such amounts as are necessary to enable the obligated group members to comply with the terms of the Subordinate MTI, including payment of the outstanding obligations. In addition, each subordinate limited designated affiliate has an independent subordinate limited designated affiliate agreement and promissory note with Ascension Health Alliance, with stipulated repayment terms and conditions, each subject to the governing law of the subordinate limited designated affiliate's state of incorporation. The Health Ministry is a subordinate obligated group member under the terms of the Subordinate MTI.

The borrowing portfolio of the Senior and Subordinate Credit Group includes a combination of fixed and variable rate hospital revenue bonds, commercial paper, and other obligations, the proceeds of which are in turn loaned to the Senior and Subordinate Credit Group members subject to a long-term amortization schedule of 1 to 39 years.

Certain portions of Senior and Subordinate Credit Group borrowings may be periodically subject to interest rate swap arrangements to effectively convert borrowing rates on such obligations from a floating to a fixed interest rate or vice versa based on market conditions. In addition, Senior and Subordinate Credit Group borrowings may, from time to time, be refinanced or restructured in order to take advantage of favorable market interest rates or other financial opportunities. Any gain or loss on refinancing, as well as any bond premiums or discounts, are allocated to the Senior and Subordinate Credit Group members based on their pro rata share of the Senior and Subordinate Credit Group's obligations. Senior and Subordinate Credit Group refinancing transactions rarely have a significant impact on the outstanding borrowings or intercompany debt amortization schedule of any individual Senior and Subordinate Credit Group member.

The carrying amounts of intercompany debt with Ascension Health Alliance and other debt approximate fair value based on a portfolio market valuation provided by a third party.

5. Long-Term Debt (continued)

The Senior and Subordinate Credit Group financing documents contain certain restrictive covenants, including a debt service coverage ratio.

As of June 30, 2012, the Senior Credit Group has a line of credit of $1,000,000 which may be used as a source of funding for unremarketed variable rate debt (including commercial paper) or for general corporate purposes, toward which bank commitments totaling $1,000,000 extend to November 9, 2014. As of June 30, 2012 and 2011, there were no borrowings under the line of credit.

As of June 30, 2012, the Subordinate Credit Group has a $50,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $50,000 extends to December 27, 2012. As of June 30, 2012, $26,607 of letters of credit had been extended under the revolving line of credit, although there were no borrowings under any of the letters of credit.

The outstanding principal amount of all hospital revenue bonds is $4,451,285 which represents 41% of the combined unrestricted net assets of the Senior and Subordinate Credit Group members at June 30, 2012.

Guarantees are contingent commitments issued by the Senior and Subordinate Credit Groups, generally to guarantee the performance of a sponsored organization or an affiliate to a third party in borrowing arrangements such as commercial paper issuances, bond financing, and similar transactions. The term of the guarantee is equal to the term of the related debt, which can be as short as 30 days or as long as 27 years. The maximum potential amount of future payments the Senior and Subordinate Credit Groups could be required to make under its guarantees and other commitments at June 30, 2012, is approximately $170,000.

During the years ended June 30, 2012 and 2011, interest paid was approximately $6,048 and $6,383, respectively.

6. Pension Plans

The Health Ministry participates in the Ascension Health Pension Plan and the Ascension Health Defined Contribution Plan. Details of these plans are as follows.

Ascension Health Pension Plan

The Health Ministry participates in the Ascension Health Pension Plan (the Ascension Plan), a noncontributory defined benefit pension plan that covers substantially all eligible employees of certain System entities. Benefits are based on each participant's years of service and compensation. The Ascension Plan's assets are invested in the Ascension Health Master Pension Trust (the Trust), a master trust consisting of cash and cash equivalents, equity, fixed income funds, and alternative investments. The Trust also invests in derivative instruments, the purpose of which is to economically hedge the change in the net funded status of the Ascension Plan for a significant portion of the total pension liability that can occur due to changes in interest rates. Contributions to the Ascension Plan are based on actuarially determined amounts sufficient to meet the benefits to be paid to plan participants. Net periodic pension cost of $1,437 in 2012 and $9,846 in 2011 was charged to the Health Ministry. The service cost component of net periodic pension cost charged to the Health Ministry is actuarially determined while all other components are allocated based on the Health Ministry's pro rata share of Ascension Health's overall projected benefit obligation.

During the year ended June 30, 2012, the System approved and communicated to employees a redesign of associate retirement benefits, which affects the Ascension Plan as well as provides an enhanced comprehensive defined contribution plan. These changes will become effective January 1, 2013. These changes resulted in the Health Ministry's recognition of a nonrecurring curtailment gain of $20,098 during the year ended June 30, 2012. These changes also resulted in one-time decreases to the projected benefit obligation of $19,395. The projected benefit obligation is included in pension and other postretirement liabilities in the accompanying consolidated balance sheets.

The assets of the Ascension Plan are available to pay the benefits of eligible employees of all participating entities. If participating entities are unable to fulfill their financial obligations under the Ascension Plan, the other participating entities are obligated to do so. As of June 30, 2012, the Ascension Plan had a net unfunded liability of $267,828. The Health Ministry's allocated

6. Pension Plans (continued)

share of the Ascension Plan's net unfunded liability reflected in the accompanying consolidated balance sheets at June 30, 2012 and 2011, was $16,704 and $16,610, respectively. As a result of updating the funded status of the Plan, the Health Ministry's allocated share of the Plan's net funded liability was reduced by $1,319, net and $21,213 during 2012 and 2011, respectively. These adjustments are included in pension and other postretirement liability adjustments in the accompanying consolidated statements of operations and changes in net assets.

As of June 30, 2012 and 2011, the fair value of the Ascension Plan's assets available for benefits was $3,948,293 and $3,616,141, respectively. As discussed in Note 4, the Health Ministry, as well as the System, follows a three-level hierarchy to categorize assets and liabilities measured at fair value. In accordance with this hierarchy, as of June 30, 2012, 16%, 51%, and 33% of the Ascension Plan's assets that are measured at fair value on a recurring basis were categorized as Level 1, Level 2, and Level 3, respectively. With respect to the Ascension Plan's liabilities measured at fair value on a recurring basis, 6%, 87%, and 7% were categorized as Level 1, Level 2, and Level 3, respectively, as of June 30, 2012. In addition, as of June 30, 2011, 27%, 45%, and 28% of the Ascension Plan's assets that are measured at fair value on a recurring basis were categorized as Level 1, Level 2, and Level 3, respectively. With respect to the Ascension Plan's liabilities measured at fair value on a recurring basis, 0%, 17%, and 83% were categorized as Level 1, Level 2, and Level 3, respectively, as of June 30, 2011.

Ascension Health Defined Contribution Plan

The Health Ministry participates in the Ascension Health Defined Contribution Plan (the Defined Contribution Plan), a contributory and noncontributory defined contribution plan sponsored by Ascension Health, which covers all eligible associates. There are three primary types of contributions to the Defined Contribution Plan: employer automatic contributions, employee contributions, and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant's salary and increase over specified periods of employee service. These benefits are funded annually, and participants become fully vested over a period of time. Benefits for employer matching contributions are determined as a percentage of an eligible participant's contributions each payroll period. These benefits are funded each payroll period, and participants become fully vested in all employer contributions immediately. Defined contribution expense, representing both employer automatic contributions and employer matching contributions, was $5,025 and $4,322 for the years ended June 30, 2012 and 2011, respectively.

7. Self-Insurance Programs

The Health Ministry participates in pooled risk programs to insure professional and general liability risks and workers' compensation risks to the extent of certain self-insured limits. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. Actuarially determined amounts, discounted at 6%, are contributed to the trusts and the captive insurance company to provide for the estimated cost of claims. The loss reserves recorded for estimated self-insured professional, general liability, and workers' compensation claims include estimates of the ultimate costs for both reported claims and claims incurred but not reported and are discounted at 6% in 2012 and 2011. If sufficient funds are not available from the self-insurance programs, each participating entity may be assessed its pro rata share of the deficiency. If contributions exceed the losses paid, the excess may be returned to participating entities.

Professional and General Liability Programs

The Health Ministry participates in Ascension Health's professional and general liability self-insured program which provides claims-made coverage through a wholly owned onshore trust and offshore captive insurance company, Ascension Health Insurance, Ltd. (AHIL), with a self-insured retention of $10,000 per occurrence with no aggregate. The Health Ministry has a deductible of $100 per claim. Excess coverage is provided through AHIL with limits up to $185,000. AHIL retains $5,000 per occurrence and $5,000 annual aggregate for professional liability. AHIL also retains a 20% quota share of the first $25,000 of umbrella excess. The remaining excess coverage is reinsured by commercial carriers.

Professional liability coverage is provided on an occurrence basis through a wholly owned onshore trust with a self-insured retention of $250 per occurrence and $7,500 in aggregate in compliance with participation in the Patient Compensation Fund. The Patient Compensation Fund applies to claims in excess of the primary self-insured limit. General liability coverage is provided on a claims-made basis through a wholly owned onshore trust and offshore captive insurance company, AHIL, with a self-insured retention of $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $185,000. AHIL also retains a 20% quota share of the first $25,000 of umbrella excess. The remaining excess coverage is reinsured by commercial carriers. The Health Ministry has a deductible of $100 for both professional and general liability claims.

(Dollars in Thousands)

7. Self-Insurance Programs (continued)

Included in operating expenses in the accompanying consolidated statements of operations and changes in net assets is professional and general liability expense of $2,137 and $4,740 for the years ended June 30, 2012 and 2011, respectively. Included in current and long-term self-insurance liabilities on the accompanying consolidated balance sheets are professional and general liability premiums owed to the self-insured trust of approximately $3,689 and $4,227, at June 30, 2012 and 2011, respectively.

Workers' Compensation

The Health Ministry participates in Ascension Health's workers' compensation program, which provides occurrence coverage through a grantor trust. The trust provides coverage up to $1,000 per occurrence with no aggregate. The trust provides a mechanism for funding the workers' compensation obligations of its members. Excess insurance against catastrophic loss is obtained through commercial insurers. Premium payments made to the trust are expensed and reflect both claims reported and claims incurred but not reported.

Included in operating expenses in the accompanying consolidated statements of operations and changes in net assets is workers' compensation expense of $1,428 and $1,507 for the years ended June 30, 2012 and 2011, respectively.

8. Lease Commitments

Future minimum payments under noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:	
2013	$ 10,815
2014	10,255
2015	9,103
2016	5,660
2017	4,671
Thereafter	13,194
Total	$ 53,698

8. Lease Commitments (continued)

The Health Ministry has subleased certain of its space under the operating leases reported above. Total future minimum rents to be received under noncancelable subleases with terms of one year or more are $2,044.

In prior years, the System entered into agreements to lease four parcels of land to an unrelated third party to construct and operate medical office buildings (MOBs) on the premises. Under the first lease, annual payments of $51 are due from the lessee, beginning on February 1, 1999, and continuing for a 51½-year period. Beginning with the second lease year through the term of the lease, rental payments increase by an amount equal to 2.00% of the rent of the previous year. The lessee has the option to extend the term of the lease for an additional ten-year period. Under the second lease, quarterly payments of $14 are due from the lessee, beginning on July 26, 2004, and continuing for a 76½-year period. Beginning with the 2007 lease year through and including the 2016 lease year, rental payments increase by an amount equal to 2.75% of the rent of the previous year. After the 2016 lease year, rent will increase by the lesser of 2.75% of the immediately preceding lease year or the consumer price index as defined by the lease agreement. The lessee has the option to extend the term of the lease for an additional ten-year period. Under the third lease, quarterly payments of $15 are due from the lessee, beginning on May 1, 2002, and continuing for a 76½-year period. Beginning with the 2005 lease year through and including the 2014 lease year, rental payments increase by an amount equal to 2.75% of the rent of the previous year. After the 2015 lease year, rent will increase by the lesser of 2.75% of the immediately preceding lease year or the consumer price index as defined by the lease agreement. The lessee has the option to extend the term of the lease for an additional ten-year period. Under the fourth lease, quarterly payments of $46 are due from the lessee, beginning on October 1, 2003, and continuing for a 76½-year period. Beginning with the 2005 lease year through and including the 2014 lease year, rental payments increase by an amount equal to 2.75% of the rent of the previous year. After the 2015 lease year, rent will increase by the lesser of 2.75% of the immediately preceding lease year or the consumer price index as defined by the lease agreement. The lessee has the option to extend the term of the lease for an additional ten-year period.

(Dollars in Thousands)

8. Lease Commitments (continued)

In addition, the Health Ministry is a lessor under certain operating lease agreements, primarily ground leases related to third party owned MOBs on land owned by the Health Ministry. Future minimum rental receipts under all noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:		
2013	$	2,023
2014		1,843
2015		1,521
2016		1,448
2017		1,244
Thereafter		51,684
Total	$	59,763

Rental expense under operating leases amounted to $13,421 and $12,358 in 2012 and 2011, respectively.

The Health Ministry entered into agreements to lease space in MOBs under construction by external development companies. The Health Ministry was considered the owner of the MOBs during construction. In addition, because these transactions (and the sales of other existing MOBs) did not qualify for sale-leaseback accounting, they were treated as financing transactions. Accordingly, the associated financing obligations of $12,040 and $12,215 at June 30, 2012 and 2011, respectively, are included in other noncurrent liabilities in the accompanying consolidated balance sheets. These financing obligations will not result in cash payments. All future cash obligations related to leased space within these MOBs are included as future minimum lease payments in the amounts reported above.

9. Related-Party Transactions

The Health Ministry utilized various centralized programs and overhead services of the System or its other sponsored organizations including risk management, retirement services, treasury, debt management, executive management support, administrative services, and information technology services. The charges allocated to the Health Ministry for these services represent both allocations of common costs and specifically identified expenses that are incurred by the System on behalf of the Health Ministry. Allocations are based on relevant metrics such as the Health Ministry's pro rata share of revenues, certain costs, debt, or investments to the consolidated totals of the System. The amounts charged to the Health Ministry for these services may not necessarily result in the net costs that would be incurred by the Health Ministry on a stand-alone basis. The charges allocated to the Health Ministry were approximately $26,614 and $20,613 for the years ended June 30, 2012 and 2011, respectively.

In addition to the charges discussed above, the Health Ministry made payments to the System of $7,196 and $7,564 for the years ended June 30, 2012 and 2011, respectively, representing the Health Ministry's share of costs to fund a System-wide information technology and process standardization project that is expected to continue through December 2014. These payments are included in transfers to sponsor and other affiliates, net, in the accompanying consolidated statements of operations and changes in net assets.

During the year ended June 30, 2012, the Health Ministry transferred cash and investments of $445 in support of the System's strategic initiatives.

10. Contingencies and Commitments

In September 2010, Ascension Health received a letter from the U.S. Department of Justice (the DOJ) in connection with its nationwide review to determine whether, in certain cases, implantable cardioverter defibrillators (ICDs) were provided to certain Medicare beneficiaries in accordance with national coverage criteria. In connection with this nationwide review, the Health Ministry will be reviewing applicable medical records for response to the DOJ. The DOJ's investigation spans a time frame beginning in 2004 and extending through the present time. Through August 23, 2012, the DOJ has not asserted any claims against the Health Ministry. Ascension Health and the Health Ministry continue to fully cooperate with the DOJ in its investigation.

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Sacred Heart Health System, Inc. and Subsidiaries

Our audit were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Ernst & Young LLP

September 12, 2012

Sacred Heart Health System, Inc. and Subsidiaries

Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs
(In Thousands)

The net cost excluding the provision for bad debt expense of providing care of persons living in poverty and community benefit programs is as follows:

	Year Ended June 30	
	2012	**2011**
Traditional charity care provided	**$ 17,414**	$ 16,816
Unpaid cost of public programs for persons living in poverty	**19,199**	12,983
Other programs for persons living in poverty and other vulnerable persons	**772**	771
Community benefit programs	**4,470**	4,821
Care of persons living in poverty and community benefit programs	**$ 41,855**	$ 35,391

OMB Circular A-133 Reports and Schedules

Sacred Heart Health System, Inc. and Subsidiaries

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2012

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Agency or Pass-Through Contract Number	Expenditures
U.S. Department of Education passed through the Florida Department of Health			
Special Education – Grants for Infants and Families	84.181	COQ-JP	$ 554,807
Special Education – Grants for Infants and Families	84.181	COQ-UC	692,800
			1,247,607
U.S. Department of Health and Human Services passed through the Florida Department of Health			
Temporary Assistance for Needy Families	93.558	COQ-UC	163,277
U.S. Department of Health and Human Services			
Children's Health Insurance Program	93.767	1Z0330873A	185,669
U.S. Department of Health and Human Services passed through Lutheran Services Florida, Inc. Northwest			
HIV Care Formula Grants	93.917	HV003	100,000
Total U.S. Department of Health and Human Services			448,946
U.S. Department of Homeland Security (FEMA) passed through the Florida Division of Emergency Management			
Hazard Mitigation Grant	97.039	1545-111-F	20,400
Total Federal Expenditures			$ 1,716,953

See accompanying notes.

Sacred Heart Health System, Inc. and Subsidiaries

Schedule of State Financial Assistance Projects

Year Ended June 30, 2012

State Agency and Project Title	State CSFA Number	State Contract/ Grant Number	State Expenditures
Florida Department of Health			
Area Health Education Center (AHEC) Network	64.009	FAT06	$ 287,857
Trauma Center Financial Support	64.075	TRA15	280,909
Rural Primary Care	64.123	COTEN	2,224,819
Total State Expenditures			$ 2,793,585

See accompanying notes.

Notes to Schedule of Expenditures of Federal Awards and Schedule of State Financial Assistance Projects

Year Ended June 30, 2012

1. Summary of Significant Accounting Policies

The accounting policies and presentation of the schedule of expenditures of federal awards and schedule of state financial assistance projects of Sacred Heart Health System, Inc. and subsidiaries (the Health System) have been designed to conform to accounting principles generally accepted in the United States, including the reporting and compliance requirements of the Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*.

Reporting Entity

OMB Circular A-133 sets forth the audit and reporting requirements for federal financial assistance. Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, set forth the audit and reporting requirements for state financial assistance. The schedule of expenditures of federal awards and schedule of state financial assistance projects include all federal and state financial assistance expended by the Health System.

Basis of Accounting

The schedule of expenditures of federal awards and schedule of state financial assistance projects have been prepared using the accrual basis of accounting. The accrual basis of accounting recognizes revenues when they are earned and expenditures when the related liability is incurred.

2. Contingencies

Grant monies received and disbursed by the Health System are for specific purposes and are subject to audit by the grantor agencies. Such audits may result in requests for reimbursement due to disallowed expenditures. Based on prior experience, the Health System does not believe that such disallowances, if any, would have a material effect on the financial position of the Health System.

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Report of Independent Certified Public Accountants on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance With *Government Auditing Standards*

The Board of Directors
Sacred Heart Health System, Inc. and Subsidiaries

We have audited the financial statements of Sacred Heart Health System, Inc. and Subsidiaries (the Health System) as of and for the year ended June 30, 2012, and have issued our report thereon dated September 12, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Management of the Health System is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered the Health System's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of management, the Audit Committee, the Board of Directors, others within the entity, federal and state awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Ernst + Young LLP

September 12, 2012

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Report of Independent Certified Public Accountants on Compliance With Requirements That Could Have a Direct and Material Effect on Each Major Federal Awards Program and State Financial Assistance Project and on Internal Control Over Compliance in Accordance With OMB Circular A-133, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, and on Schedule of Expenditures of Federal Awards and Schedule of State Financial Assistance Projects

The Board of Directors
Sacred Heart Health System, Inc. and Subsidiaries

Compliance

We have audited Sacred Heart Health System, Inc. and Subsidiaries' (the Health System) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Circular A-133 Compliance Supplement* and the *Department of Financial Services State Project Compliance Supplement* that could have a direct and material effect on each of the Health System's major federal programs and state financial assistance projects for the year ended June 30, 2012. The Health System's major federal programs and state financial assistance projects are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs and state financial assistance projects is the responsibility of the Health System's management. Our responsibility is to express an opinion on the Health System's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*. Those standards and OMB Circular A-133, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program or state financial assistance project occurred. An audit includes examining, on a test basis, evidence about the Health System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of the Health System's compliance with those requirements.

In our opinion, the Health System complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on each of its major federal programs and state financial assistance projects for the year ended June 30, 2012.

Internal Control Over Compliance

The management of the Health System is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs and state financial assistance projects. In planning and performing our audit, we considered the Health System's internal control over compliance with the requirements that could have a direct and material effect on a major federal program or state financial assistance project to determine the auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control over compliance.

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program or state financial assistance project on a timely basis. A material weakness in internal control over compliance is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program or state financial assistance project will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

Schedule of Expenditures of Federal Awards and Schedule of State Financial Assistance Projects

We have audited the financial statements of the Health System as of and for the year ended June 30, 2012, and have issued our report thereon dated September 12, 2012, which contained an unqualified opinion on those financial statements. Our audit was performed for the purpose of forming our opinion on the Health System's financial statements. The accompanying schedule of expenditures of federal awards and schedule of state financial assistance projects are presented for purposes of additional analysis as required by OMB Circular A-133, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain other procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the schedule of expenditures of federal awards and schedule of state financial assistance projects are fairly stated, in all material respects, in relation to the financial statements as a whole.

This report is intended solely for the information and use of management, the Audit Committee, Board of Directors, others within the entity, the Florida Auditor General and the State of Florida, and federal and state awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

March 26, 2013

Sacred Heart Health System, Inc. and Subsidiaries

Schedule of Findings and Questioned Costs

Year Ended June 30, 2012

Part I – Summary of Auditor's Results

Financial Statements Section

Type of auditor's report issued (unqualified, qualified, adverse, or disclaimer):	Unqualified			
Internal control over financial reporting:				
Material weakness(es) identified?		**Yes**	X	**No**
Significant deficiency(ies) identified?		**Yes**	X	**None reported**
Noncompliance material to financial statements noted?		**Yes**	X	**No**

Federal Awards and State Financial Assistance Projects Section

Internal control over major programs:				
Material weakness(es) identified?		**Yes**	X	**No**
Significant deficiency(ies) identified?		**Yes**	X	**None reported**
Type of auditor's report issued on compliance for major programs (unqualified, qualified, adverse, or disclaimer):	Unqualified			
Any audit findings disclosed that are required to be reported in accordance with section .510(a) of OMB Circular A-133 and with Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, State of Florida?		**Yes**	X	**No**

Part I – Summary of Auditors' Results (continued)

Identification of major programs:

CFDA Number(s)	Name of Federal Program or Cluster
CFDA 84.181	Special Education–Grants for Infants and Families
CFDA 93.558	Temporary Assistance for Needy Families (TANF)
CFDA 93.767	Children's Health Insurance Program

CSFA Number(s)	Name of State Financial Assistance Project
CSFA 64.123	Rural Primary Care

Dollar threshold used to distinguish between Type A and Type B federal programs	$ 300,000
Dollar threshold used to distinguish between Type A and Type B programs for state financial assistance projects	$ 300,000
Auditee qualified as low-risk auditee for federal purposes?	X **Yes** ____ **No**

Part II – Financial Statements Findings Section

This section identifies the significant deficiencies, material weaknesses, fraud, illegal acts, violations of provisions of contracts and grant agreements, and abuse related to the consolidated financial statements for which *Government Auditing Standards* require reporting in a Circular A-133, Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General*, audit.

No matters were reported.

Part III – Federal Award Programs and State Financial Assistance Projects Findings and Questioned Costs Section

This section identifies the audit findings required to be reported by Circular A-133 section .510(a), Section 215.97, *Florida Statutes*, and Chapter 10.650, *Rules of the Auditor General* (for example, significant deficiencies, material weaknesses, and material instances of noncompliance, including questioned costs), as well as any abuse findings involving federal awards and state financial assistance projects that are material to a major program.

No findings were noted.

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