Consolidated Financial Statements and Other Financial Information

St. Mary's Health System of America, Inc.
A Member of Ascension Health
Years Ended June 30, 2010 and 2009
With Reports of Independent Auditors

Ernst & Young LLP

St. Mary's Health System of America, Inc.

Consolidated Financial Statements
and Other Financial Information

Years Ended June 30, 2010 and 2009

Contents

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Report of Independent Auditors

The Board of Directors
St. Mary's Health System of America, Inc.

We have audited the accompanying consolidated balance sheets of St. Mary's Health System of America, Inc. (the Company) as of June 30, 2010 and 2009, 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 the Company'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. 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 the Company'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 the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide 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 St. Mary's Health System of America, Inc. at June 30, 2010 and 2009, and the consolidated results of its operations and changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

September 17, 2010

St. Mary's Health System of America, Inc.

Consolidated Balance Sheets

(Dollars in Thousands)

	June 30 2010	June 30 2009
Assets		
Current assets:		
Cash and cash equivalents	**$ 17,080**	$ 18,629
Patient accounts receivable, less allowances for uncollectible accounts ($40,600 and $60,380 in 2010 and 2009, respectively)	**69,644**	63,238
Estimated third-party payor settlements	**1,655**	960
Pledges receivable	**669**	–
Inventories	**6,452**	8,160
Other receivables	**5,406**	4,908
Other	**3,578**	5,433
Total current assets	**104,484**	101,328
Board-designated investments	**233,250**	205,975
Other investments	**104,761**	69,533
Assets limited as to use – temporarily restricted	**6,391**	6,430
Property and equipment:		
Land and improvements	**19,793**	19,793
Building and equipment	**368,799**	370,596
Less accumulated depreciation	**(278,169)**	(262,086)
	110,423	128,303
Construction in progress	**1,483**	71
Held for sale	**450**	–
Total property and equipment, net	**112,356**	128,374
Other assets:		
Investment in unconsolidated entities	**987**	467
Goodwill	**7,093**	7,093
Deferred compensation	**6,617**	5,618
Other	**3,378**	1,130
Total other assets	**18,075**	14,308
Total assets	**$ 579,317**	$ 525,948

	June 30	
	2010	**2009**
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	**$ 1,166**	$ 1,874
Accounts payable and accrued liabilities	**49,115**	43,384
Other	**3,911**	2,981
Total current liabilities	**54,192**	48,239
Noncurrent liabilities:		
Long-term debt, net of current portion	**143,370**	144,144
Pension and other postretirement liabilities	**32,897**	28,499
Deferred compensation liabilities	**6,617**	5,618
Other	**6,691**	6,961
Total noncurrent liabilities	**189,575**	185,222
Total liabilities	**243,767**	233,461
Net assets:		
Unrestricted	**328,491**	286,057
Temporarily restricted	**6,889**	6,260
Permanently restricted	**170**	170
Total net assets	**335,550**	292,487
Total liabilities and net assets	**$ 579,317**	$ 525,948

See accompanying notes.

St. Mary’s Health System of America, Inc.

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Years Ended June 30	
	2010	**2009**
Operating revenue:		
Net patient service revenue	**$ 439,372**	$ 442,389
Other revenue	**16,642**	18,106
Income from unconsolidated entities	**1,244**	454
Net assets released from restrictions for operations	**732**	710
Total operating revenue	**457,990**	461,659
Operating expenses:		
Salaries and wages	**178,473**	173,792
Employee benefits	**50,050**	41,145
Purchased services	**30,566**	29,555
Professional fees	**16,360**	15,665
Supplies	**74,217**	67,493
Insurance	**3,188**	2,834
Bad debts	**22,559**	50,086
Interest	**4,425**	5,028
Depreciation	**19,893**	19,946
Other	**40,781**	37,934
Total operating expenses before nonrecurring items	**440,512**	443,478
Income from operations before nonrecurring items	**17,478**	18,181
Nonrecurring items	**1,742**	125
Income from operations	**15,736**	18,056
Nonoperating gains (losses):		
Investment income (loss), net	**41,098**	(59,632)
Income (loss) from unconsolidated entities	**9**	(19)
Minority interest	**(3,561)**	(3,719)
Sale of interest in Sagamore HMO	**–**	1,119
Other	**(77)**	(1,216)
Total nonoperating gains (losses), net	**37,469**	(63,467)
Excess (deficiency) of revenues over expenses	**53,205**	(45,411)

Continued on next page.

St. Mary's Health System of America, Inc.

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

	Years Ended June 30	
	2010	**2009**
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	**$ 53,205**	$ (45,411)
Transfer to sponsor and other affiliates, net	**(10,678)**	(26,703)
Net assets released from restrictions for property acquisitions	**71**	144
Other	**(164)**	(1,430)
Increase (decrease) in unrestricted net assets	**42,434**	(73,400)
Temporarily restricted net assets:		
Contributions	**502**	608
Investment income (losses)	**23**	(32)
Net assets released from restrictions	**(803)**	(854)
Other	**907**	(43)
Increase (decrease) in temporarily restricted net assets	**629**	(321)
Permanently restricted net assets:		
Other	**–**	170
Increase in permanently restricted net assets	**–**	170
Increase (decrease) in net assets	**43,063**	(73,551)
Net assets at beginning of year	**292,487**	366,038
Net assets at end of year	**$ 335,550**	$ 292,487

See accompanying notes.

St. Mary's Health System of America, Inc.

Consolidated Statements of Cash Flows

(Dollars in Thousands)

	Years Ended June 30	
	2010	2009
Cash flows from operating activities		
Increase (decrease) in net assets	**$ 43,063**	$ (73,551)
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation	**19,893**	19,946
Provision for bad debts	**22,559**	50,086
Net realized and change in unrealized gains/losses on investments	**(19,996)**	21,046
Loss on sale of property	**111**	523
Gain on sale of joint venture	**–**	(1,119)
Impairment expenses	**999**	125
Net assets released for property acquisitions	**71**	144
Transfers to sponsor and other affiliates, net	**10,678**	26,703
Net changes in operating assets and liabilities:		
Patient accounts receivable, net	**(28,965)**	(52,601)
Inventories and other current assets	**2,396**	(2,412)
Investments classified as trading	**(42,468)**	22,348
Other noncurrent assets	**(3,767)**	1,756
Accounts payable and accrued liabilities	**5,731**	3,514
Estimated third-party payor settlements, net	**(695)**	(3,297)
Other current liabilities	**930**	344
Other noncurrent liabilities	**5,127**	21,023
Net cash provided by operating activities	**15,667**	34,578
Cash flows from investing activities		
Property and equipment additions, net	**(4,734)**	(11,388)
Proceeds from sale of property and equipment	**141**	207
Net assets released for property acquisitions	**(71)**	(144)
Proceeds from sale of joint ventures	**–**	1,119
Net cash used in investing activities	**(4,664)**	(10,206)
Cash flows from financing activities		
Repayment of long-term debt	**(1,874)**	(1,869)
Transfers to sponsor and other affiliates, net	**(10,678)**	(26,703)
Net cash used in financing activities	**(12,552)**	(28,572)
Net decrease in cash and cash equivalents	**(1,549)**	(4,200)
Cash and cash equivalents at beginning of year	**18,629**	22,829
Cash and cash equivalents at end of year	**$ 17,080**	$ 18,629

See accompanying notes.

1. Organization and Mission

Organizational Structure

St. Mary's Health System of America, Inc. (Health Ministry) is a member of Ascension Health. Ascension Health is a Catholic national health system consisting primarily of nonprofit corporations that own and operate local health care facilities, or health ministries, located in 20 of the United States and the District of Columbia. Ascension Health is sponsored by the Northeast, Southeast, East Central, and West Central Provinces of the Daughters of Charity of St. Vincent de Paul, the Congregation of St. Joseph, and the Congregation of the Sisters of St. Joseph of Carondelet.

The Health Ministry, located in Evansville, Indiana, is a nonprofit acute care hospital system. The Health Ministry's primary market is an area extending in a 75-mile radius from Evansville. The Health Ministry's primary operations consist of two acute care hospitals: St. Mary's Medical Center and St. Mary's Warrick (the Hospitals), located in Evansville, Indiana, and Boonville, Indiana, respectively. The Hospitals provide inpatient, outpatient, and emergency care services for the residents of Vandeburgh, Warrick, and surrounding counties. Admitting physicians are primarily practitioners in the local area. The Health Ministry also owns and operates a home health agency, four medical office buildings, off-site primary care centers, a breast center for women's health, and two outpatient surgery centers. The Health Ministry 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.

Mission

Ascension Health 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 which sustains and improves the health of the individuals and communities it serves. In accordance with Ascension Health's mission of service to those who are poor and vulnerable, each health ministry accepts patients regardless of their ability to pay. Ascension Health uses four categories to identify the resources utilized for the care of persons who are poor 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.

1. Organization and Mission (continued)

- Unpaid cost of public programs represents the unpaid cost of services provided to persons covered by public programs for the poor.

- Cost of other programs for the poor includes unreimbursed costs of programs intentionally designed to serve the poor and vulnerable 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 poor, 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 who are poor and community benefit programs. The cost of providing care of persons who are poor and community benefit programs is estimated using internal cost data and is calculated in compliance with guidelines established by both the Catholic Health Association (CHA) and the Internal Revenue Service (IRS).

The amount of traditional charity care provided is determined based on the qualifying criteria, as defined in the charity care policy, through approved applications completed by patients and their families or beneficiaries. In 2010, the Health Ministry expanded its policy to include those who did not apply for charity care, but were determined to be unable to pay based on an analysis of certain criteria performed by a third-party vendor. No payment for services is anticipated for those patients whose charity care applications have been approved, as well as for those other patient accounts identified who meet certain other criteria. The amount of traditional charity care provided, determined on the basis of cost, excluding the provision for bad debt expense, was approximately $16,096 and $8,075 for the years ended June 30, 2010 and 2009, respectively. The amount of unpaid cost of public programs, cost of other programs for the poor, and community benefit cost are reported in the accompanying other financial information.

(Dollars in Thousands)

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 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 for such entities included in the consolidated excess (deficiency) of revenues over expenses in the consolidated statements of operations and changes in net assets:

	Investment Recorded in the Consolidated Balance Sheets as of June 30		Effect on Consolidated Excess (Deficiency) of Revenues over Expenses for the Years Ended June 30	
	2010	**2009**	**2010**	**2009**
Radiation Oncology of Southern Indiana	**$ 486**	$ 374	**$ 872**	$ 394
St. Mary's Acute Dialysis Services, LLC	**326**	–	**314**	–
Other	**175**	93	**67**	41
	$ 987	$ 467	**$ 1,253**	$ 435

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

Carrying value of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of financial instruments classified other than current assets and current liabilities are disclosed in Note 4 and Note 5.

2. Significant Accounting Policies (continued)

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with maturities of three months or less and certain highly liquid interest-bearing securities with maturities that may extend longer than three months but are convertible to cash within a one-month time period under the terms of the agreement with the investment manager.

Investments and Investment Return

The Health Ministry holds investments through the Health System Depository (HSD), an investment pool of funds in which a limited number of nonprofit health care providers participate for purposes of establishing investment goals and monitoring performance under agreed-upon socially responsible investment guidelines. The investments are managed by external investment managers within established investment guidelines. The value of the Health Ministry's investment in the HSD represents the Health Ministry's pro rata share of the HSD's investments held for participants. At June 30, 2010 and 2009, the Health Ministry's investment in the HSD was $344,574 and $286,033, respectively.

The Health Ministry also invests in common stocks, government securities, and corporate obligations which are locally managed. All of these funds are locally managed and held in the Health Ministry's consolidated foundation. The Health Ministry reports both its investment in the HSD and in locally managed investments in the accompanying consolidated balance sheets based upon the long- or short-term nature of its investment and whether such investments are restricted by law or donors or designated for specific purposes by a governing body of Ascension Health.

The HSD's assets required to be recorded at fair value are comprised of equity and various fixed income investments. The HSD also holds investments in hedge funds, private equity, and real estate funds, which are recorded under the equity method of accounting. In addition, the HSD participates in securities lending transactions whereby a portion of its investments is loaned to selected established brokerage firms in return for cash and securities from the brokers as collateral for the investments loaned.

2. Significant Accounting Policies (continued)

Investment returns are comprised of dividends, interest, and gains and losses. The cost of substantially all securities sold is based on the average cost method. All of the Health Ministry's investments, including its investment in the HSD, are designated as trading investments. Accordingly, all investment returns, including unrealized gains and losses, are reported as non-operating gains or losses in the consolidated statements of operations and changes in net assets, except for returns restricted by donor or law.

Pledges Receivable

Unconditional promises to give cash or other assets to the St. Mary's Medical Center Foundation, Inc. are recognized as pledges receivable on the consolidated balance sheets and as contributions within the appropriate net asset category.

Inventories

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

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date the gift is received. Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Estimated useful lives by asset category are as follows: land improvements – 20 to 25 years; buildings – 30 to 40 years; and equipment – 3 to 20 years.

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. Temporarily restricted net assets and earnings on permanently restricted net assets 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.

2. Significant Accounting Policies (continued)

Performance Indicator

The performance indicator is the excess or deficiency of revenues over expenses, which includes operating income and nonoperating income and losses. The performance indicator excludes all changes in unrestricted net assets, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, and contributions of property and equipment.

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, 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 and certain gains and losses from investments in unconsolidated entities which do not pertain to the mission.

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 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 $739 and $2,903 for the years ended June 30, 2010 and 2009, respectively.

During 2010 and 2009, approximately 29.9% and 26.6%, respectively, of net patient service revenue was received under the Medicare program, 21.4% and 16.7%, respectively, under Blue Cross, and 4.1% and 3.6%, respectively, under various state Medicaid programs. The Health

2. Significant Accounting Policies (continued)

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 accounts receivable at June 30, 2010 and 2009, include Medicare (26.9% and 21.5%, respectively) and various states' Medicaid (24.8% and 16.5%, respectively) programs.

The provision for bad debts 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 debts 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. During 2010, the Health Ministry recharacterized certain prior year bad debt write-offs to charity care totaling $18,853.

In 2010, the Health Ministry executed an agreement to transfer certain patient accounts receivable with recourse to a third party in exchange for cash at a discounted rate. The Health Ministry is deemed to have retained the risk of ownership of the receivables, which serve as collateral for the cash advanced to the Health Ministry, and continues to reflect the receivables and related liability to the third party in patient accounts receivable and accounts payable and accrued liabilities in the accompanying consolidated balance sheets. As of June 30, 2010, receivables subject to this arrangement were $1,583.

Nonrecurring Expenses

During the years ended June 30, 2010 and 2009, the Health Ministry recorded nonrecurring expenses of $743 and $0, respectively, relating to changes in business operations. In addition long-lived asset impairment charges of $999 and $125 for 2010 and 2009 were recorded. The 2010 impairment was recorded on equipment no longer in use and being held for sale. The fair value of the impaired asset was estimated using Level 3 inputs. The 2009 impairment was for a medical office building that was condemned as the result of a fire.

2. Significant Accounting Policies (continued)

New Accounting Standards

In January 2010, the Financial Accounting Standards Board (FASB) issued guidance that clarifies certain existing fair value measurement disclosure requirements and also requires additional fair value measurement disclosures. Specifically, the guidance clarifies that assets and liabilities must be leveled by major class of asset or liability, and provides guidance regarding the identification of such major classes. Additionally, disclosures are required about valuation techniques and the inputs to those techniques, for those assets or liabilities designated as Level 2 or Level 3 instruments. Disclosures regarding transfers between Level 1 and Level 2 assets and liabilities are required, as well as a deeper level of disaggregation of activity within existing rollforwards of the fair value of Level 3 assets and liabilities. The adoption of this guidance did not have a significant impact on the Health Ministry's consolidated financial statements for the year ended June 30, 2010.

In December 2008, the FASB issued additional authoritative guidance regarding an employer's disclosures about postretirement benefit plan assets. This guidance requires disclosure about the major classes of postretirement benefit plan assets, including a description of the inputs and valuation techniques used to measure those assets and the designation of such assets by level; how investment allocation decisions are made; the effect of fair value measurements using significant unobservable inputs on changes in plan assets for the period; and significant concentrations of risk within plan assets. The adoption of this guidance did not have a significant impact on the Health Ministry's consolidated financial statements for the year ended June 30, 2010.

In September 2006, the FASB issued authoritative guidance on fair value measurements, which was adopted by Ascension Health for the year ended June 30, 2009. This guidance provides a definition of fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements impacting certain assets and liabilities. See Note 4 for fair value measurement disclosures for the years ended June 30, 2010 and 2009.

2. Significant Accounting Policies (continued)

In April 2009, accounting guidance was issued for mergers and acquisitions involving not-for-profit entities. This guidance establishes principles to assist not-for-profit entities in determining if a combination is to be accounted for as a merger or an acquisition. The guidance applies the carryover (similar to pooling) method to accounting for a merger, and the purchase accounting method to accounting for an acquisition, and clarifies the valuation basis to be used in determining the values of the assets and liabilities being acquired. In addition, this guidance makes provisions related to goodwill and noncontrolling interests fully applicable to not-for-profit entities. This accounting guidance is effective for fiscal years beginning after December 15, 2009, or for mergers (as defined in the new accounting guidance) that occur after December 15, 2009, and retroactive application is prohibited. This new guidance will be applied prospectively to future business combinations.

In January 2010, the FASB issued guidance regarding the definition and presentation of noncontrolling interests. This guidance will be effective for the Health Ministry for the year ended June 30, 2011. The adoption of this guidance will change the presentation of noncontrolling (minority) interests in the consolidated financial statements.

In July 2010, the FASB also issued guidance that clarified and defined the calculation of charity care to the community for which not-for-profit entities disclose. The guidance is effective for fiscal years ending after December 15, 2010. The Health Ministry does not anticipate the guidance will have any material impact on its disclosures of charity care.

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). The Health Ministry accounts for uncertainty in income tax positions by applying a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return.

Reclassifications

Certain reclassifications were made to the 2009 consolidated financial statements to conform to the 2010 presentation. These reclassifications had no impact on the change in net assets previously reported.

(Dollars in Thousands)

3. Cash and Cash Equivalents, Investments, and Other Assets Limited as to Use

The Health Ministry's cash and investments are comprised of the Health Ministry's pro rata share of the HSD's funds held for participants and certain other investments such as those investments held and managed by foundations. Board-designated investments represent investments designated by resolution of the Board of Directors 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 investments are reported in the accompanying consolidated balance sheets as presented in the following table:

	June 30	
	2010	**2009**
Cash and cash equivalents	**$ 17,080**	$ 18,629
Board-designated investments	**233,250**	205,975
Other investments	**104,761**	69,533
Assets limited as to use – temporarily restricted	**6,391**	6,430
Total	**$ 361,482**	$ 300,567

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

	June 30	
	2010	**2009**
Cash, cash equivalents, and short-term investments	**$ 11,169**	$ 8,403
U.S. government obligations	**981**	1,516
Corporate and foreign fixed income investments	**878**	721
Equity securities	**3,680**	3,590
Other investments	**200**	304
Subtotal, included in cash and cash equivalents, short-term investments, board-designated investments, assets limited as to use, and other investments	**16,908**	14,534
Pro rata share of HSD funds held for participants	**344,574**	286,033
Cash and cash equivalents, short-term investments, board-designated investments, assets limited as to use, and other investments	**$ 361,482**	$ 300,567

(Dollars in Thousands)

3. Cash and Cash Equivalents, Investments, and Other Assets Limited as to Use (continued)

As of June 30, 2010 and 2009, the composition of total HSD investments is as follows:

	June 30	
	2010	**2009**
Cash, cash equivalents and short-term investments	**5.8%**	10.6%
U.S. government obligations	**26.0**	16.5
Asset-backed securities	**11.3**	20.8
Corporate and foreign fixed income investments	**17.5**	18.0
Equity securities and other investments	**39.4**	34.1
Total	**100.0%**	100.0%

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

	Year Ended June 30	
	2010	**2009**
Investment return in HSD	**$ 40,442**	$ (58,634)
Interest and dividends	**176**	240
Net gains (losses) on other investments	**503**	(1,270)
Total investment return	**$ 41,121**	$ (59,664)
Investment return included in operating income	**$ –**	$ –
Investment return included in nonoperating gains (losses)	**41,098**	(59,632)
Increase (decrease) in restricted net assets	**23**	(32)
Total investment return	**$ 41,121**	$ (59,664)

4. Fair Value Measurements

The Health Ministry adopted the FASB's authoritative accounting guidance on fair value measurements for the fiscal year ended June 30, 2009, as well as updated fair value measurement guidance for the fiscal year ended June 30, 2010. In accordance with this guidance, assets and liabilities recorded at fair value in the financial statements are categorized, for disclosure purposes, based upon whether the inputs used to determine their fair values are observable or unobservable. The Health Ministry follows the three-level fair value hierarchy to categorize these assets and liabilities which prioritizes the inputs used to measure assets and liabilities at fair value. Level inputs are defined as follows:

Level 1 – Quoted prices (unadjusted) in active markets 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. 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 – Inputs that are unobservable for the asset or liability.

Assets and liabilities classified as Level 1 are valued using unadjusted quoted market prices for identical assets or liabilities in active markets. The Health Ministry uses techniques consistent with the market approach and income approach for measuring fair value of its Level 2 and Level 3 assets and liabilities. The market approach is a valuation technique that uses prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities. The income approach generally converts future amounts (cash flows or earnings) to a single present value amount (discounted).

4. Fair Value Measurements (continued)

As of June 30, 2010, and June 30, 2009, the Level 2 and Level 3 assets and liabilities listed in the fair value hierarchy tables below utilize the following valuation techniques and inputs:

Cash and cash equivalents and short-term investments: Short-term investments designated as Level 2 investments are primarily comprised of commercial paper, whose fair value is based on amortized cost. Significant observable inputs include security cost, maturity and credit rating. Cash and cash equivalents and additional short-term investments are primarily comprised of certificates of deposit, whose fair value is based on cost plus accrued interest. Significant observable inputs include security cost, maturity, and relevant short-term interest rates.

U.S. government obligations: The fair value of investments in U.S. government, state, and municipal obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

Corporate and foreign fixed income investments: 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.

Other investments: The fair value of other investments, which consist of a parcel of donated land, is determined by a real estate appraisal from an unrelated third party.

As discussed in Note 2 and Note 3, the Health Ministry has an investment in the HSD and certain other investments, such as those investments held and managed by foundations. As of June 30, 2010, 25%, 67%, and 8% of total HSD 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 2%, 45%, and 53% of total HSD 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, 2009, 27%, 68%, and 5% of total HSD 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 6%, 45%, and 49% of total HSD liabilities that are 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, 2010, for all other financial assets and liabilities not held in the HSD which are measured at fair value on a recurring basis in the consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2010				
Cash and cash equivalents	$ 10,880	$ –	$ –	$ 10,880
Short-term investments	172	117	–	289
U.S. government obligations	–	981	–	981
Corporate and foreign fixed income investments	–	878	–	878
Equity securities	3,680	–	–	3,680
Other investments	–	–	200	200
Subtotal, included in cash and cash equivalents, short-term investments, board-designated investments, assets limited as to use, and other investments	$ 14,732	$ 1,976	$ 200	$ 16,908
Deferred incentive compensation assets invested in mutual funds and guaranteed pooled funds	$ 4,781	$ –	$ 1,836	$ 6,617

(Dollars in Thousands)

4. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2009, 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, 2009				
Cash and cash equivalents	$ 8,207	$ –	$ –	$ 8,207
Short-term investments	82	114	–	196
U.S. government obligations	–	1,516	–	1,516
Corporate and foreign fixed income investments	–	721	–	721
Equity securities	3,590	–	–	3,590
Other investments	104	–	200	304
Subtotal, included in cash and cash equivalents, short-term investments, board-designated investments, assets limited as to use, and other investments	$ 11,983	$ 2,351	$ 200	$ 14,534
Deferred incentive compensation assets invested in mutual funds and guaranteed pooled funds	$ 3,857	$ –	$ 1,761	$ 5,618

During the years ended June 30, 2010 and 2009, there were no transfers in or out of the foregoing assets measured using significant unobservable inputs (Level 3).

(Dollars in Thousands)

5. Long-Term Debt

Long-term debt consists of the following:

	June 30	
	2010	**2009**
Intercompany debt with Ascension Health, payable in installments through November 2047; interest (3.9% and 3.9% at June 30, 2010 and 2009, respectively) adjusted based on prevailing blended market interest rate of underlying debt obligations	**$ 144,536**	$ 146,003
Other	**–**	15
	144,536	146,018
Less current portion	**1,166**	1,874
Long-term debt, less current portion	**$ 143,370**	$ 144,144

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

Year ending June 30:	
2011	$ 1,166
2012	993
2013	938
2014	2,099
2015	2,196
Thereafter	137,144
Total	$ 144,536

Certain members of Ascension Health formed the Ascension Health Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member or a 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. Though senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with Ascension Health with stipulated repayment terms and conditions, each subject to the governing law of the limited designated affiliate's state of incorporation. In

5. Long-Term Debt (continued)

addition, Ascension Health may cause each senior designated affiliate to transfer such amounts as are necessary to enable the senior obligated group members to comply with the terms of the Senior MTI, including payment of the outstanding obligations. 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.

A Subordinate Credit Group, which is comprised of subordinate obligated group members 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. Though subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI, each subordinate limited designated affiliate has an independent limited designated affiliate agreement and promissory note with Ascension Health with stipulated repayment terms and conditions, each subject to the governing law of the 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 37 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. Additionally, 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

5. Long-Term Debt (continued)

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. Members of Ascension Health may also periodically draw from the invested funds of other members of Ascension Health on a relatively short-term basis and subject to certain conditions.

During the year ended June 30, 2010, Ascension Health completed multiple debt transactions which ultimately resulted in an increase of $15,744 to the total debt of Ascension Health. As a result of these transactions, the Health Ministry's pro rata portion of intercompany debt to Ascension Health increased approximately $441 reflected as a transfer from sponsor and other affiliates, net, in the accompanying consolidated statements of operations and changes in net assets for the year ended June 30, 2010.

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

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

As of June 30, 2010, the Senior Credit Group has a line of credit of $250,000 related to its commercial paper program toward which bank commitments totaling $250,000 extend to November 18, 2010. As of June 30, 2010 and 2009, there were no borrowings under the line of credit.

As of June 30, 2010, the Senior Credit Group has a line of credit of $500,000 for general corporate purposes, toward which bank commitments totaling $500,000 extend to April 2, 2012. As of June 30, 2010, there were no borrowings under the line of credit.

As of June 30, 2010, 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 29, 2010. As of June 30, 2010, $37,033 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 $4,130,280, which represents 48% of the combined unrestricted net assets of the Senior and Subordinate Credit Group members at June 30, 2010.

5. Long-Term Debt (continued)

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 29 years. The maximum potential amount of future payments the Senior and Subordinate Credit Groups could be required to make under its guarantees, letters of credit and other commitments at June 30, 2010, is approximately $125,000.

During the years ended June 30, 2010 and 2009, interest paid was approximately $4,425 and $5,028, 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 sponsored by Ascension Health, which covers all eligible employees of certain Ascension Health 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 $7,549 in 2010 and $6,708 in 2009 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.

The assets of the Ascension Plan are available to pay the benefits of eligible employees of all participating entities. In the event participating entities are unable to fulfill their financial obligations under the Ascension Plan, the other participating entities are obligated to do so. As of

6. Pension Plans (continued)

June 30, 2010, the Ascension Plan had a net unfunded liability of $649,818. The Health Ministry’s allocated share of the Ascension Plan’s net unfunded liability reflected in the accompanying consolidated balance sheets at June 30, 2010 and 2009, was $32,897 and $28,499, respectively. As a result of updating the funded status of the Plan, Ascension Health transferred an additional pension liability of $2,217 and $21,448 to the Health Ministry during 2010 and 2009, respectively. These transfers are included in transfers from (to) sponsor and other affiliates, net, in the accompanying consolidated statements of operations and changes in net assets.

Ascension Health adopted the measurement date provision of existing authoritative guidance on employers’ accounting for defined-benefit pension and other postretirement plans as of June 30, 2009. As a result, Ascension Health transferred an additional pension liability of $971 to the Health Ministry, which is included in transfers from (to) sponsor and other affiliates, net, in the accompanying consolidated statements of operations and changes in net assets for the year ended June 30, 2009.

As of June 30, 2010 and 2009, the fair value of the Ascension Plan’s assets available for benefits was $3,089,076 and $2,525,941, respectively. As discussed in Note 4, the Health Ministry, as well as Ascension Health, follows a three-level hierarchy to categorize assets and liabilities measured at fair value. In accordance with this hierarchy, as of June 30, 2010, 29%, 42%, and 29% of the Ascension Plan’s assets which are measured at fair value on a recurring basis were categorized as Level 1, Level 2, and Level 3 investments, respectively. With respect to the Ascension Plan’s liabilities measured at fair value on a recurring basis, 0%, 13%, and 87% were categorized as Level 1, Level 2, and Level 3, respectively, as of June 30, 2010.

Ascension Health Defined Contribution Plan

The Health Ministry participates in the Ascension Health Defined Contribution Plan (the Defined Contribution Plan), a noncontributory, defined contribution plan sponsored by Ascension Health and which covers all eligible associates. There are two primary types of contributions to the Defined Contribution Plan: employer automatic contributions and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant’s salary and increases over specified periods of employee service. These benefits are funded annually. 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

6. Pension Plans (continued)

period. Participants become fully vested in all employer contributions immediately. Defined contribution expense, representing both employer automatic contributions and employer matching contributions, was $3,894 and $631 for the year ended June 30, 2010 and 2009, respectively.

7. Self-Insurance Programs

The Health Ministry participates in self-insurance programs through Ascension Health for 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 2010 and 2009. In the event that 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.

General/Professional 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 on-shore trust and offshore captive insurance company. The Health Ministry has a deductible of $100 per claim and the program has a self-insured retention of $10,000 per occurrence with no aggregate. Excess coverage is provided through Ascension Health Insurance Limited (AHIL), a wholly owned captive insurance company 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.

7. Self-Insurance Programs (continued)

The Corporation is subject to the provisions of the Indiana Medical Malpractice Act which limits the maximum recovery for professional liability to $1,250 per occurrence, and an aggregate of $5,000 or $7,500, based on the size of the hospital, in compliance with participation in the State of Indiana Patient Compensation Fund. The first $250 per occurrence would be paid by the Ascension Health Trust Fund, and the balance would be paid by the State of Indiana Patient Compensation Fund.

Included in operating expenses in the accompanying consolidated statements of operations and changes in net assets is general and professional liability expense of $2,371 and $1,939 for the years ended June 30, 2010 and 2009, respectively. The general and professional liability reserves included in current and long-term liabilities in the accompanying consolidated balance sheets were approximately $1,443 at June 30, 2010 and 2009.

Workers' Compensation

The Health Ministry participates in Ascension Health's workers' compensation self-insurance program, which provides occurrence coverage through a grantor trust. The self-insured retention of 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 through self-insurance and excess insurance against catastrophic loss. 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 $1,012 and $1,222 for the years ended June 30, 2010 and 2009, respectively.

Medical Insurance Claims

The Health Ministry is self-insured for medical and dental benefits provided to its employees. The Health Ministry estimates its liability for covered medical claims, including claims incurred but not reported, based upon historical costs incurred and payment processing experience. At June 30, 2010 and 2009, the liability for such covered medical claims was $3,837 and $2,838, respectively, and is included in accounts payable and accrued liabilities in the accompanying consolidated balance sheets.

(Dollars in Thousands)

8. Lease Commitments

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

Year ending June 30:	
2011	$ 6,818
2012	6,753
2013	6,438
2014	5,126
2015	4,331
Thereafter	19,668

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

Year ending June 30:	
2011	$ 1,129
2012	817
2013	351
2014	251
2015	251
Thereafter	5,971

Rental expense under operating leases amounted to $9,228 and $8,426 in 2010 and 2009, respectively.

9. Related-Party Transactions

The Health Ministry utilized various centralized programs and overhead services of Ascension Health 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 Ascension Health on behalf of the Health Ministry. Allocations are based on relevant metrics

9. Related-Party Transactions (continued)

such as the Health Ministry's pro rata share of revenues, certain costs, debt, or investments to the consolidated totals of Ascension Health. 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 $2,445 and $2,377 for the years ended June 30, 2010 and 2009, respectively.

During 2010 and 2009, the Health Ministry transferred cash and investments of $3,636 and $4,174, respectively, in support of Ascension Health's strategic initiatives.

The Health Ministry utilizes professional services from another member of Ascension Health. This arrangement was initiated in January 2010 and resulted in expense for the year ended June 30, 2010, of $1,212, which is also the amount payable, and is included in accounts payable and accrued liabilities in the accompanying consolidated balance sheet at June 30, 2010.

10. Contingencies and Commitments

In addition to professional liability claims, the Health Ministry is involved in litigation and regulatory investigations arising in the ordinary course of business. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the Health Ministry's consolidated financial position and results of operations

The Health Ministry enters into agreements with non-employed physician groups to provide professional medical services which include minimum revenue guarantees. Certain of these guarantees are secured by the accounts receivable and cash collections of the physician groups, which are considered when determining the fair value of these guarantees. At June 30, 2010, and 2009, the Health Ministry recorded net liabilities related to these guarantees in the amount of $599 and $0, respectively, which is included in other current and noncurrent liabilities in the accompanying consolidated balance sheets. These agreements have various expirations dates through 2011.

The Health Ministry also has guaranteed, with its joint venture partner, lease payments for two pieces of equipment currently being utilized in the unconsolidated joint venture. The Health Ministry estimates the fair market value of its portion of the guaranty is $0 at June 30, 2010, and June 30, 2009. At June 30, 2010, the maximum exposure to the Health Ministry for this guarantee is $949.

11. Health Care Legislation and Regulation

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, governmental health care program participation requirements, reimbursement for patient services, Medicare and Medicaid fraud and abuse, and security, privacy, and standards of health information. Government activity has continued with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and noncompliance with regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, significant repayments for patient services previously billed, and disruptions or delays in processing administrative transactions, including the adjudication of claims and payment.

Various federal and state agencies have initiated investigations regarding reimbursement claimed by the Health Ministry. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of these investigations will not have a material adverse impact on the consolidated financial statements of the Health Ministry.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act*. The legislation, among other matters, is designed to expand access to coverage to substantially all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing Medicare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Regulations to implement these legislative acts are in the process of being developed and, accordingly, the specific impact of the legislation on the Health Ministry is not determinable at this time.

12. Subsequent Events

The Health Ministry evaluates the impact of subsequent events, 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 or disclosure in the notes to the consolidated financial statements. The Health Ministry evaluated events occurring subsequent to June 30, 2010, through September 17, 2010, the date on which the accompanying consolidated financial statements were available to be issued. During this period, there were no subsequent events that required recognition in the consolidated financial statements. Additionally, there were no non-recognized subsequent events that required disclosure.

Other Financial Information

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Report of Independent Auditors on Other Financial Information

The Board of Directors
St. Mary's Health System of America, Inc.

Our audits were conducted for the purpose of forming an opinion on the basic consolidated financial statements taken as a whole. The schedule of net cost of providing care of persons who are poor and community benefit programs is presented for purposes of additional analysis and is not a required part of the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in our audits of the basic consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic consolidated financial statements taken as whole.

Ernst & Young LLP

September 17, 2010

St. Mary's Health System of America, Inc.

Schedule of Net Cost of Providing Care of Persons
Who Are Poor and Community Benefit Programs
(Dollars in Thousands)

The net cost excluding the provision for bad debt expense of providing care of persons who are poor and community benefit programs is as follows:

	Year Ended June 30	
	2010	**2009**
Traditional charity care provided	**$ 16,096**	$ 8,075
Unpaid cost of public programs for the poor	**22,469**	18,123
Other programs for the poor	**635**	642
Community benefit programs	**1,932**	1,036
Net cost of providing care of persons who are poor and community benefit programs	**$ 41,132**	$ 27,876

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