THE OHIO STATE UNIVERSITY
HEALTH SYSTEM

(A SERIES OF DEPARTMENTS OF THE OHIO STATE UNIVERSITY)

Consolidated Financial Statements as of June 30, 2012 and 2011 and for the Year Ended June 30, 2012, Report of Independent Auditors and Report of Independent Auditors on Internal Control over Financial Reporting and of Compliance and Other Matters

Dave Yost • Auditor of State

Board of Directors
The Ohio State University Health System
2040 Blankenship Hall
901 Woody Hayes Drive
Columbus, Ohio 43210

We have reviewed the *Report of Independent Auditors* of The Ohio State University Health System, Franklin County, prepared by Pricewaterhouse Coopers LLP, for the audit period July 1, 2011 through June 30, 2012. Based upon this review, we have accepted these reports in lieu of the audit required by Section 117.11, Revised Code. The Auditor of State did not audit the accompanying financial statements and, accordingly, we are unable to express, and do not express an opinion on them.

Our review was made in reference to the applicable sections of legislative criteria, as reflected by the Ohio Constitution, and the Revised Code, policies, procedures and guidelines of the Auditor of State, regulations and grant requirements. The Ohio State University Health System is responsible for compliance with these laws and regulations.

Dave Yost
Auditor of State

January 4, 2013

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THE OHIO STATE UNIVERSITY HEALTH SYSTEM

TABLE OF CONTENTS

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Report of Independent Auditors

To the Board of Trustees of
The Ohio State University

In our opinion, the accompanying consolidated statements of net assets and the related statement of revenues, expenses, and changes in net assets, and cash flows, present fairly, in all material respects, the financial position of The Ohio State University Health System (the "Health System"), a series of departments of The Ohio State University (the "University") as of June 30, 2012 and 2011, and the changes in its financial position and its cash flows for the year ended June 30, 2012 in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Health System's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America 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. An audit 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 accordance with *Government Auditing Standards*, we have also issued our report dated November 9, 2012 on our consideration of the 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.

As discussed in Note 1, the financial statements of the Health System present only the financial position, changes in financial position, and cash flows of that portion of the financial reporting entity of The Ohio State University that is attributable to the transactions of the Health System. They do not purport to, and do not, present fairly the financial position of The Ohio State University at June 30, 2012 and June 30, 2011, and the changes in its financial position or its cash flows for the year ended June 30, 2012 in conformity with accounting principles generally accepted in the United States of America.

The accompanying management's discussion and analysis on pages 2 through 12 are required by accounting principles generally accepted in the United States of America to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in the appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

PricewaterhouseCoopers LLP

November 9, 2012

Introduction

The following discussion and analysis provides an overview of the financial position of The Ohio State University Wexner Medical Center Health System (the "Health System") at June 30, 2012 and 2011, and its activities for the fiscal year ended June 30, 2012. This discussion has been prepared by management and should be read in conjunction with the financial statements and the notes thereto, which follows this section.

About The Ohio State University Wexner Medical Center Health System

The Ohio State University Wexner Medical Center is one of the nation's leading academic medical centers. As a part of the Wexner Medical Center, the Health System operates under the governance of The Ohio State University Board of Trustees and is comprised of The Ohio State University Hospital, The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Richard M. Ross Heart Hospital, University Hospital East, OSU Harding Hospital, Dodd Rehabilitation Hospital, three comprehensive outpatient care centers, an ambulatory surgery center, a comprehensive breast treatment center, and 23 clinics. The System provided services to more than 56,000 adult inpatients and 1,220,000 outpatients during Fiscal Year 2012.

The Health System operates nearly 1,200 inpatient beds and serves as a major tertiary and quaternary referral center for Ohio and the Midwest. Its Signature programs in Cancer, Critical Care, Imaging, Heart, Neurosciences and Transplantation provide personalized patient care. The Wexner Medical Center has 10 nationally ranked specialties in US News and World Report. It is designated as a Level I Trauma Center, has the only adult burn center in Central Ohio, and is home to a Level III neonatal intensive care unit.

A $1.1 billion construction project broke ground in 2010, representing the largest development project in The Ohio State University's history. Once complete, the new Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, a Critical Care Center, as well as integrated, state-of-the-art research facilities will provide scientists, researchers and clinicians with a single collaborative environment for research, education and patient care. This 1.1 million square foot building will include 276 cancer beds and 144 critical care beds. Construction is expected to be completed in 2014, and more than 300,000 patients will be served annually when the facility is opened.

In October, 2011 the Medical Center converted to a single, integrated and personalized health record across the continuum of a patient's interaction with the Medical Center (IHIS). All members of the Medical Center team now use the same system to access and enter information into the inpatient and outpatient medical and financial records. In May 2012, Wexner Medical Center was the first hospital in Ohio and among only 86 of the more than 5,000 hospitals in the nation to achieve the highest designation for electronic medical record adoption.

Operating and Financial Highlights

	Fiscal Year June 30,	
	2012	2011
Selected Statistics		
Admissions	56,170	56,869
Avg. Daily Census	910	883
Outpatient Visits	1,270,726	1,096,992
Emergency Visits	122,499	120,625
Surgeries	37,700	36,417

In 2012, the Health System experienced strong activity levels and remained financially sound. Consistent with national trends, inpatient admissions dropped modestly, most notably due to the continued

movement of patient care to an outpatient environment and the increased use of observation beds. These drops were offset by gains in more complicated surgical, neurological, transplant and cardiovascular admissions, which contributed to increases in revenues, average length of stay and average daily census.

Inpatient surgeries increased approximately 2.0%, while outpatient surgeries increased 4.7%. Outpatient visits increased 15% over the previous year, as the Health System continued its ambulatory strategy and opened the CarePoint East ambulatory facility and The James Breast Center. Continued growth was experienced at other CarePoint facilities, primary care locations, and specialty clinics.

	Fiscal Year June 30,	
	2012	2011
Income and Change in Net Assets	(in millions)	
Operating Revenue	$ 1,913.5	$ 1,706.0
Operating Expenses	1,738.3	1,553.5
Operating Income	175.2	152.5
Non Operating Revenues (Expenses)	(2.0)	(8.0)
Transfers of contributions for property acquisitions	24.7	
Income before other changes in net assets	197.9	144.5
Medical Center investments	$ (99.0)	$ (83.5)
Contributions for property acquisitions	34.9	9.0
Additions to Permanent Endowments	3.8	
Other Changes in Net Assets	-	(12.7)
Changes in Net Assets	$ 137.6	$ 57.3
Net Assets Beginning of Year	651.9	594.6
Net Assets End of Year	$ 789.5	$ 651.9

Operating revenues grew over $207 million, or 12.2% from the prior year. Approximately one third of the increase was driven by increased activity levels discussed above, with the remaining increase resulting from higher case intensity, sustained payor mix, and increased rates from third party payers. Included in Operating Revenue is a onetime recognition for the James of approximately $10.3 million receivable from Medicare for previous years cost reports.

Operating expenses grew at 11.9%, mirroring changes in activities, price increases, and onetime expenses associated with the medical record implementation. Salaries and Benefits were up approximately 10%. Adjusted for activities, there was a 20% growth in drug expenses due to more expensive chemotherapy agents being used and price volatility due to uncertain drug availability. Increases in drug expenses also result in increased revenue, much of which is reimbursable given contractual relationships. Adjusted for activities, supply costs growth was limited to approximately 3%, as strategic sourcing initiatives kept price increases down.

Property contributions received by the University in prior years relating to the Health System's capital expansion project totaled $24.7 million and have been recorded as a one-time Transfer of contributions for property acquisitions in the current year. Including this amount, Income before other changes in net assets was approximately $197.9 million versus $144.5 million in 2011. Excluding the Medicare receivable and the transfer of contributions noted above, income before other changes in net assets grew by approximately 8% over 2011, reflecting strong outpatient activities, a strong patient mix and maintaining expenses in line with activities.

Changes to Net Assets included $99.0 million reinvested back into research, education, and programs at the Medical Center. Additionally, the Medical Center was awarded a $100 million grant from The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health & Human Services, in support of the new tower construction. Approximately $30.4 million of the total grant was recognized under Contribution for Property Acquisitions as a change in net assets. The remaining amounts will be funded by HRSA on a cost sharing basis, once the allowable costs have been incurred. Additionally, $4.5 million of other restricted expendable funds and pledges received in support of the tower expansion and other Health System initiatives have been recorded. In total, after accounting for these changes, the Health System's net assets increased approximately $137.6 million.

As with all healthcare providers, we will be challenged by the impact of Healthcare Reform. Uncertainty in the upcoming elections and the potential repeal of existing reform legislation continues to complicate the environment. Regardless, the Medical Center continues to position itself to thrive in the changing market, as it has successfully done in the past. The clinical component of the medical staff activities has been integrated into the OSU Faculty Group Practice, located under the Office of Health Science. This provides the Health System and the medical staff a unified structure to manage changes in reimbursement, change in practice patterns and alignment in strategies. We are working with the University Health Plan and government waiver programs to begin management of specific patient populations, a key component of reform. We will actively work with other healthcare providers locally and statewide, and may form strategic alliances when beneficial to our patients and the Medical Center. We continue to consolidate administrative functions across the Medical Center, eliminating redundancy wherever possible.

Despite the challenges and the changing healthcare environment, the Health System expects to improve its financial position and operating results during the upcoming year, and will continue to play a key role in supporting the Medical Center and in its status as a leading academic medical center.

Using the Financial Statements

The System's financial report includes three financial statements: the Consolidated Statement of Net Assets; the Consolidated Statement of Revenues, Expenses and Changes in Net Assets; and the Consolidated Statement of Cash Flows. These financial statements are prepared in accordance with Governmental Accounting Standards Board ("GASB") principles.

Fiscal Year ended June 30, 2011 was the first year for a standalone audit of the consolidated statement of net assets of the Health System. Previously, the Health System's financial results were audited and reported as a part of the larger Ohio State University Audit.

In its 2012 consolidated financial statements, the Health System began to record pledges, endowment fund assets, and bequests of support from corporations, foundations and individuals in support of capital expansion and patient care activities based upon the concurrent determination that the underlying activities are to be recorded in the Health System.

Consolidated Statement of Net Assets

The statement of net assets presents the financial position of the System at the end of the fiscal year and includes all assets and liabilities of the System. The difference between total assets and total liabilities – net assets – is one indicator of the current financial condition of the System, while the change in net assets is an indication of whether the overall financial condition has improved or worsened during the year. A comparison of the System's assets, liabilities, and net assets at June 30, 2012 and 2011 is summarized as follows:

	2012	2011
	(in millions)	
Current assets	$ 450.1	$ 399.4
Noncurrent assets		
Assets Whose Use is Limited	189.1	317.3
Capital assets, net	864.4	661.4
Other	30.1	11.3
Total assets	1,533.7	1,389.4
Current liabilities	127.3	126.1
Current portion of		
Long-term debt	34.5	32.5
Total current liabilities	161.8	158.6
Noncurrent liabilities		
Long-term debt	511.7	494.9
Other noncurrent liabilities	70.7	84.0
Total liabilities	744.2	737.5
Net assets	$ 789.5	$ 651.9

Current Assets and Current Liabilities

	2012	2011
	(in millions)	
Current Assets		
Cash on deposit with the University	$ 154.2	$ 151.5
Patient accounts receivable, net	255.3	206.0
Inventories, Prepaids, Other Receivables	40.6	41.9
Total Current Assets	**$ 450.1**	**$ 399.4**

Cash on deposit with the University represents the Health System cash, which is pooled with other operating units within the University. These funds earn interest income at rates established through the University's internal bank program. The increase in cash balances resulted from recognition of $15.6 million of restricted expendable cash in support of property acquisitions and patient care activities offset in part from increased working capital needs and in part from an extra bi-weekly payroll paid during fiscal year 2012.

Patient accounts receivable represent amounts due from third party payors and patients after allowances for discounts and bad debts. The Health System implemented its Integrated Healthcare Information System (IHIS) in October 2011. This implementation not only replaced most existing clinical systems, but also included replacement of patient management, patient access, and billing systems. By the end of the fiscal year, the Health System achieved pre-implementation metrics in third party receivables, after allowing for an increase in the payment period implemented by Medicare. Receivables increased approximately $49 million reflecting not only the change in that payment period, but also reflecting the 15% increase in outpatient activities and higher third party rates negotiated with managed care organizations.

Overall, Inventories, Prepaid Expenses and other current assets increased slightly. Offsetting this increase was reclassification of receivable from OSUP to a long term asset and an adjustment from Medicare under its periodic interim payment program (PIP) to OSU Hospitals.

	2012	2011
	(in millions)	
Current Liabilities		
Accounts Payable & Accrued Expenses	$ 95.5	$ 67.1
Accrued Salaries & Benefits	28.2	43.5
Current Portion Long Term Debt	34.5	32.5
Third-party payor settlements	3.6	15.5
Total Current Liabilities	**$ 161.8**	**$ 158.6**

Payables and accrued expenses increased from timing of payables runs, an increase in AR credit balances, and recognition of deferred revenue on payments due from OSU Physicians on the electronic medical record implementation. Accrued salaries decreased because of the payment of the extra payroll mentioned above. The decrease in payable to third parties reflects current payment adjustments due to the James in FY 2012, but not received until FY 2013.

Assets whose use is limited

	2012	2011
	(in millions)	
Assets whose use is limited		
Construction funds held for MCE	$ 27.2	$ 155.6
Other	161.9	161.7
Total Assets Limited as to Use	**$ 189.1**	**$ 317.3**

Assets whose use is limited is composed of funds set aside for specific purposes. Construction funds held for MCE are funds set aside for the Medical Center Expansion project. These funds represent unspent bond proceeds assignable from Ohio State University to the Health System, and are included in the discussion in the next section. Other funds include funds set aside for capital use, research initiatives, and debt service.

Capital Assets, Medical Center Expansion, and Long Term Debt

	2012	2011
	(in millions)	
Capital Assets - Net		
Property, Plant, and Equipment	$ 1,129.3	$ 1,029.4
Construction In Progress	416.7	245.5
Accumulated Depreciation	(681.6)	(613.5)
Capital Assets - Net	**$ 864.4**	**$ 661.4**

Medical Center Expansion construction continues on the tower containing the new James Cancer Hospital and new critical care units. Scheduled to open in 2014, it has capacity for 420 new beds, 348 of which will be in service at opening.

Components of Medical Center Expansion include the already completed 2 floor addition to the Ross Heart Hospital, the construction of a new MRI facility, and north Doan renovations. In total, the cost of the project is expected to be $1.1 billion dollars, with major components as follows:

Medical Center Expansion	Cost
Cancer & Critical Care Tower	$ 742.7
Infrastructure and Roadways	92.2
Upgrades to existing facilities, demolition	100.3
Ross, Doan and MRI additions	82.8
BRT buildout and other projects	27.3
Project planning and support	54.7
Total Costs	**$ 1,100.0**

The Medical Center applied to the Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health & Human Services, for a grant under the Infrastructure to Expand Access to Care Program. The Ohio State University Wexner Medical Center was selected as the sole recipient of a $100 million grant to help fund its research and tertiary care efforts. This grant was awarded through a competitive grant program created by the Patient Protection and Affordable Care Act. Through June 2012, $30.4 million has been drawn on the grant and used in support of construction and is included in Other Changes in Net Assets. The remaining amounts will be funded by HRSA on a cost sharing basis, once the allowable costs have been incurred. Including this $30.4 million, a total of $211.8 was spent on MCE construction costs in 2012 and $111.0 was spent in 2011. Total project costs to date, including HRSA funded costs, are $475.6 million.

MCE is largely financed through University issued general receipts bonds which are allocated in part to the Health System through Memorandums of Understanding (MOUs). As a part of the University's bond offering in October 2010, the Health System borrowed $304.5 million for MCE. These proceeds were used to fund current and future construction and to pay back previous short term borrowings. In fiscal year 2012, the Health System added an additional $37.5 million to the MOU. These borrowings have an interest rate of 4.95% and are being serviced over 20 years. A total of $33.3 million of principal and interest were paid on all MCE MOUs in 2012.

Unspent bond proceeds are accounted for as construction funds on the books of the Health System. Interest payments incurred on the MOUs are also being capitalized during the period of construction. $16.6 million and $11.0 of interest costs were capitalized during 2012 and 2011 respectively.

In addition, the Health System expended $68.9 million for equipment, renovations and infrastructure for routine capital not related to MCE.

Other Long Term Assets and Long Term Liabilities

	2012	2011
	(in millions)	
Long Term Assets		
Investment in Subsidiaries	11.2	10.1
Pledges and Other Long Term Receivables	19.0	1.2
Total Long Term Assets	**$ 30.2**	**$ 11.3**

The Health System has investment interests in a community based air ambulance/intensive care transport and in a joint venture with partial ownership in a community hospital. The change in investment reflects the Health System's equity interest in these investments. In 2012, a long term receivable of approximately $6.5 million was reclassified from Other Current Receivables, reflecting OSUP portion of IHIS implementation costs. Additionally, $11.6 million of long term pledge receivables and endowment assets were recognized.

	2012	2011
	(in millions)	
Noncurrent Liabilities		
Third Party Liabilities	$ 13.7	$ 28.9
Accrued compensated absences	49.0	44.2
Other noncurrent liabilities	8.0	10.9
Total Long Term Liabilities	**$ 70.7**	**$ 84.0**

The decrease in Payable to Third Parties reflects adjustments to estimated future cost report settlements and reflects the recognition of the $10.3 million in Tefra rebasing settlements due to The James. Accrued Compensated Absences reflect future liabilities that the Health System may have for payout of vacation and ill time upon an employee's termination or retirement. The increase in 2012 is reflective of increase salaries and a larger workforce. The decrease in other noncurrent liabilities reflects amortization of deferred revenue arising from OSU Physicians' rights to use the integrated medical record.

Net Assets

Net assets represent the residual interest in the System's assets after liabilities are deducted. The composition of the System's net assets at June 30, 2012 and 2011 is summarized as follows:

	2012	2011
	(in millions)	
Net Assets		
Invested in Capital, Net of Related Debt	$ 318.3	$ 133.9
Restricted, nonexpendable	3.8	-
Restricted, expendable	27.5	-
Unrestricted	439.9	518.0
Net Assets	**$ 789.5**	**$ 651.9**

Net assets invested in capital assets are the system's capital assets net of accumulated depreciation and outstanding principal balances of debt obtained for acquiring, constructing, and improving those assets. While unrestricted net assets are not subject to externally imposed donor or government stipulations, the System's net assets are designated for various clinical, education, and research programs and initiatives, as well as capital projects.

Consolidated Statement of Revenues, Expenses, and Change in Net Assets

The Statement of Revenues, Expenses, and Changes in Net Assets presents the System's results of operations. A comparison of revenues, expenses and other changes in net assets for the years ended June 30, 2012 and 2011 is as follows:

	Fiscal Year June 30,	
	2012	2011
Income and Change in Net Assets	(in millions)	
Operating Revenue	$ 1,913.5	$ 1,706.0
Operating Expenses	1,738.3	1,553.5
Operating Income	175.2	152.5
Non Operating Revenues (Expenses)	(2.0)	(8.0)
Transfers of contributions for property acquisitions	24.7	
Income before other changes in net assets	197.9	144.5
Medical Center investments	$ (99.0)	$ (83.5)
Contributions for property acquisitions	34.9	9.0
Additions to Permanent Endowments	3.8	
Other Changes in Net Assets	-	(12.7)
Changes in Net Assets	$ 137.6	$ 57.3
Net Assets Beginning of Year	651.9	594.6
Net Assets End of Year	$ 789.5	$ 651.9

Operating Revenues

Operating revenues grew over $207 million, or 12.2% from the prior year. Approximately one third of the increase was driven by increased activity levels discussed previously, with the remaining increase resulting from higher case intensity, sustained payor mix, and increased rates from third party payers. Much of the activity increase was driven by increased outpatient activities, as total outpatient visits increased over 15%. This growth was driven by a combination of the opening of CarePoint Lewis Center and James Cancer Breast Center and other outpatient clinic locations, as well as the trend nationally toward outpatient treatment.

Approximately 97% of total operating revenues are from patient care activities. Other operating revenue is composed of items such as reference labs, cafeteria operations, rental agreements and other sources.

	Fiscal Year June 30,	
	2012	2011
	(in millions)	
Revenues		
Patient Service Revenue	$ 1,854.7	$ 1,658.2
Other Operating Revenues	58.8	47.8
Total Operating Revenue	**$ 1,913.5**	**$ 1,706.0**

Gross patient revenue reflects charges to patients for clinical services provided. Most patients have insurance coverage which pays for those services (third party payors). As is common in the industry, most reimbursement from third party payors are at a substantial discount from patient charges.

The major third party payors are **Medicare** - the federal program for the aged; **Medicaid** – the state program covering various underserved constituencies; and **Managed Care** – health coverage typically provided by employers through various insurance companies.

Medicare pays most inpatient and outpatient care on prospectively determined case rates. Additional payments are made to the Health System for medical education, caring for a disproportionate share of low income patients, certain transplant costs, and cases with unusually high cost of care. Additionally, The James is one of 11 cancer hospitals nationwide exempt from the inpatient prospective payment system. As such, Medicare reimburses The James reasonable inpatient costs of care (subject to limitation), determined through annual cost reports. CMS has recently completed a special audit of these hospitals and has retroactively updated the cost limitations for fiscal years 2007 through 2011. The impact of this "rebasing" of cost limits is a gain of approximately $10.3 million, which has been recorded in Patient Service Revenue in 2012. Medicare pays the James on prospectively determined outpatient rates, subject however to minimum floors.

The Health System has estimated and recorded settlement amounts for all unsettled Medicare and Medicaid cost reports through June 30, 2012. In the opinion of Management, adequate provisions have been made for such settlements. The Health System records changes in estimates upon receiving interim or final settlements related to prior year cost reports.

Subject to income and asset levels, **Medicaid** pays for care under its Programs for pregnant women, Children and Families; aged blind and disabled Program; and premium assistance for Medicare Program. As with Medicare, Medicaid pays for inpatient and outpatient services on prospectively determined case rates, with provision for cases having unusually high costs. As an exempt hospital for Medicare, The James is exempt from the case based system for Medicaid and is reimbursed for the reasonable cost of inpatient and outpatient services provided to patients.

Contracts with **Managed Care** organizations are negotiated and include different payment methods. Many of the contracts are case based or per diem for inpatients, with combination of case rates and percent of charges for outpatients. Managed Care organizations may also offer plans to Medicare and Medicaid beneficiaries. These plans typically pay negotiated rates, but usually on a basis consistent with traditional Medicare or Medicaid plans. The State of Ohio mandates that patients eligible under Programs for Children, Pregnant Women and Families enroll in a Medicaid managed care plan. It is expected that patients eligible under the Aged, Blind and Disabled program will be mandated to enroll in a managed care plan during 2013.

The Health System also has contractual relationships with other payors. It provides much of the acute care needs for The Ohio Department of Corrections, has relationships with various Bureau of Workers Comp managed care payors, and other state and federal agencies.

The Health System provides care to patients without insurance. It participates in Ohio's Hospital Care Assurance Program which provides for free care to patients whose income levels are below 100% of the Federal Poverty Guidelines (FPL). The Health System also provides sliding scale charity discounts for self pay patients up to 400% of the FPL.

Payor mix for the Health System has remained relatively constant throughout the past several years. The decrease in Self Pay and Other is partly due to reduced activities with The Ohio Department of Corrections and an partly due to earlier identification of alternative payor sources for self pay patients. The payor mix for the 2012 and 2011 fiscal years are as follows:

Payor Mix	**2012**	**2011**
Managed Care	39.0%	38.1%
Medicaid	16.3%	16.4%
Medicare	33.8%	33.5%
Self Pay and Other	10.9%	12.0%
	100.0%	100.0%

Operating Expenses

A comparison of operating expenses for the two years ended June 30, 2012 is summarized as follows:

	Fiscal Year June 30,	
	2012	2011
	(in millions)	
Expenses		
Salaries and Benefits	$ 914.2	$ 827.0
Supplies and Drugs	385.8	340.7
Purchased Services	275.7	233.5
Depreciation	76.0	69.8
Other Expenses	86.6	82.5
Total Operating Expenses	**$ 1,738.3**	**$ 1,553.5**

The Health System employs over 10,000 full time equivalent employees, up approximately 600 over 2011. As previously mentioned, this growth comes in large part from the opening of new facilities and a higher case intensity. The extensive training required with the IHIS implementation required the Health System to expand its training staff and utilize overtime to train more than 14,000 care givers, clinicians, and patient management personnel. Adjusted for activities, Salaries grew by approximately 5% while Benefits increased approximately 8.8% due to increases in medical costs.

Adjusted for activities, there was a 20% growth in drug expenses due to more expensive chemotherapy agents being used and price volatility due to uncertain drug availability. Increases in drug expenses also result in increased revenue, much of which is reimbursable given contractual relationships. Adjusted for activities, supply costs growth was limited to approximately 3.0%, as strategic sourcing initiatives kept price increases down. Purchased Services expenses were up over 18% over prior year. Hospital Franchise fees increased by almost $14.0 million as a part of the State's biennium budget, but additional operating revenue was also realized to offset the expense growth. Preventive maintenance expenses grew as expanded imaging capacity was added across additional ambulatory facilities and system support fees were up with the implementation of IHIS. Advertising was increased to support statewide and local media efforts. Depreciation increased with the addition of equipment and renovations. Substantially all of the expenditures associated with the new Cancer Hospital and Critical Care Tower are recorded as Construction in Progress, for which no depreciation expense is recorded.

Non Operating Revenue and Expenses

The Health System incurred a total of $26.1 million in interest expense, with the majority paid to the University to service debt incurred on behalf of the Health System. Of this amount costs, $9.5 million is recognized as a period cost. The remaining $16.6 of interest is for incurred for the construction of the MCE, and is being capitalized as a cost of the asset. The Health System recognized $4.7 million in gifts in 2012; however, investment income was off approximately 12%, reflecting the weakness in the financial markets,

Income before changes in Net Assets

The Ohio State University Health System posted Income before changes in net assets of $197.9 million after a one-time $24.7 million recognition of Contributions for property acquisitions that the University had received in prior years. This compares to Income before changes in net assets of $144.5 million in 2011. This increase in income allowed continued strengthening of the balance sheet in support of the Medical Center Expansion project and investments in research and educational programs.

Consolidated Statement of Cash Flows

The Consolidated Statement of Cash Flows provides additional information about the System's results by major sources and uses of cash. A comparative summary of cash flows for June 30, is:

	2012	2011
	(in millions)	
Cash flows		
Receipts from patients and third-party payors	$ 1,793.6	$ 1,650.6
Payments to and on behalf of employees	(990.6)	(877.7)
Payments to vendors for supplies and services	(615.2)	(566.9)
Other operating activities	10.2	(8.7)
Net cash provided by operating activities	$ 198.0	$ 197.3
Cash flows from non capital financing activities	8.2	-
Cash flows from capital financing activities	(100.7)	(87.3)
Cash flows from investing activities	(102.8)	(83.5)
Net (decrease) increase in cash	2.7	26.5
Cash at beginning of year	151.5	125.0
Cash at end of year	$ 154.2	$ 151.5

Cash and Cash Equivalents provided from operations totaled $198.0, approximately equal to 2011. Although the Health System had higher margins, working capital requirements increased by approximately $28 million, as an receivables increased and an extra payroll was disbursed in 2012, offset by increased payables and recognition of cash balances from gifts for patient care and capital projects. Cash flows from capital financing activities decreased as the Health System debt service to support Medical Center Expansion grew. Cash flow from investing activities decreased as additional funds were reinvested in research, education and clinical programs at the Medical Center.

Future Direction

The Medical Center is actively positioning itself to respond to Healthcare Reform. We have aggressively implemented cutting edge information technology strategies and continue to enhance leading edge tertiary care delivery across a broader geographic area. Over the past several years, our ambulatory strategy has significantly expanded our presence in the community, and coupled with the Integration of the medical staff into the Faculty Group Practice we are providing a unified framework to manage changes in reimbursement, change in practice patterns and alignment in strategies. We are working with the University Health Plan and government waiver programs to begin management of specific patient populations, a key component of reform. We will actively work with other healthcare providers locally and statewide, and may form strategic alliances when beneficial to our patients and the Medical Center. We continue to consolidate administrative functions across the Medical Center, eliminating redundancy wherever possible.

THE OHIO STATE UNIVERSITY HEALTH SYSTEM
STATEMENTS OF NET ASSETS
(in thousands)

Assets	**June 30, 2012**	**June 30, 2011**
Current assets:		
Cash and cash equivalents on deposit with the University	$ 154,203	$ 151,526
Patient accounts receivable, net of estimated uncollectibles of $37,757 in 2012 and $33,765 in 2011	255,281	205,991
Pledges receivable, net	1,375	-
Other receivables	13,719	18,063
Inventory	20,920	20,212
Prepaid expenses and other assets	4,565	3,631
Total current assets	450,063	399,423
Assets Whose Use is Limited		
Funds held for capital replacement	85,973	85,316
Funds held for debt retirement	28,031	28,031
Funds held for research initiatives	20,000	20,000
University held funds	55,047	183,906
Investment in subsidiaries	11,186	10,146
Capital assets, net	864,401	661,362
Long term pledge receivables, net	7,825	-
Long term receivables and other assets	11,168	1,174
Total noncurrent assets	1,083,631	989,935
Total assets	$ 1,533,694	$ 1,389,358
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	$ 95,533	$ 67,117
Accrued salaries and benefits	28,172	43,467
Third-party payor settlements	3,641	15,489
Current portion of long-term debt and capital leases	34,467	32,546
Total current liabilities	161,813	158,619
Long-term debt and capital leases less current portion	511,659	494,921
Compensated absences	49,049	44,245
Third-party payor settlements less current portion	13,716	28,839
Other long term liabilities	7,954	10,859
Total noncurrent liabilities	582,378	578,864
Total liabilities	744,191	737,483
Net Assets		
Invested in capital assets, net of related debt	318,275	133,895
Restricted:		
Nonexpendable	3,782	-
Expendable	27,471	-
Unrestricted	439,975	517,980
Total net assets	789,503	651,875
Total liabilities and net assets	$ 1,533,694	$ 1,389,358

The accompanying notes are an integral part of the consolidated financial statements.

THE OHIO STATE UNIVERSITY HEALTH SYSTEM
STATEMENT OF REVENUES, EXPENSES AND CHANGES IN NET ASSETS
(in thousands)

	Year Ended June 30, 2012
Operating Revenues	
Net patient service revenue (net of provision for bad debts of $90,212)	$ 1,854,720
Other revenue	58,825
Total Operating Revenue	1,913,545
Operating Expenses	
Salaries and benefits	914,235
Supplies and drugs	385,795
Purchased services	275,658
Depreciation	75,984
Other expenses	86,670
Total Expenses	1,738,342
Operating Income	175,203
Non-Operating Revenues (Expenses)	
Interest expense	(9,517)
Income from investments	2,843
Gifts	4,720
Other non-operating revenues(expenses)	(88)
Total Non-Operating Revenues (Expenses)	(2,042)
Transfers of contributions for property acquisitions	24,763
Income Before Other Changes in Net Assets	197,924
Other Changes in Net Assets	
Medical Center investments	(99,002)
Contributions for property acquisitions	34,924
Additions to permanent endowments	3,782
Total Other Changes in Net Assets	(60,296)
Increase in Net Assets	137,628
Net Assets - Beginning of Year	651,875
Net Assets - End of Year	$ 789,503

The accompanying notes are an integral part of the consolidated financial statements.

THE OHIO STATE UNIVERSITY HEALTH SYSTEM
STATEMENT OF CASH FLOWS
(in thousands)

	Year Ended June 30, 2012
Cash flows from operating activities	
Receipts from patients and third-party payors	$ 1,793,634
Other receipts	59,887
Payments to and on behalf of employees	(990,611)
Payments to vendors for supplies and services	(615,204)
Payments on other expenses	(49,706)
Net cash provided by operating activities	198,000
Cash flows from non-capital financing activities	
Gift receipts for current use	4,389
Additions to permanent endowments	3,782
Net cash provided by non-capital financing activities	8,171
Cash flows from capital financing activities	
Proceeds from issuance of long-term debt	16,423
Purchase of capital assets	(68,937)
Repayments of long-term debt and capital lease obligations	(35,264)
Cash paid for interest	(25,089)
Contributions and transfers for property acquisitions	12,157
Net cash used in capital financing activities	(100,710)
Cash flows from investing activities	
Medical Center investments	(99,002)
Purchase of long term investments	(3,782)
Net cash used in investing activities	(102,784)
Net increase in cash and cash equivalents	2,677
Cash and cash equivalents at beginning of year	151,526
Cash and cash equivalents at end of year	$ 154,203
Reconciliation of operating income to net cash provided by operating activities	
Operating Income	175,203
Adjustments to reconcile operating income to net cash provided by operations:	
Depreciation	75,984
Changes in operating assets and liabilities:	
Increase in patient accounts receivable	(49,290)
Decrease in other receivables	6,791
Decrease in third party payor settlements	(26,971)
Decrease in accrued salaries and benefits	(15,295)
Increase in compensated absences	4,804
Increase in accounts payable and accrued expenses	28,416
Increase in inventories	(708)
Increase in prepaid expenses and other assets	(934)
Net cash provided by operating activities	$ 198,000

The accompanying notes are an integral part of the consolidated financial statements.

NOTE 1 – ORGANIZATION

The Ohio State University Health System (the "Health System" or the "System") operates under the governance of The Ohio State University Board of Trustees. The Health System is comprised of a series of departments representing the financial activities of The Ohio State University Hospital, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, The Richard M. Ross Heart Hospital, The Ohio State University Hospital East, OSU Harding Hospital, The Ohio State University Ambulatory Care, The Ohio State University Specialty Care Network and several affiliates. As a series of departments of The Ohio State University (the "University"), the System is included in the consolidated financial statements of the University and is exempt from income taxes under Internal Revenue Code Section 115.

The Health System is an operating unit of The Ohio State University Wexner Medical Center ("OSUWMC") which also includes the College of Medicine, Office of Health Sciences, OSU Physicians, and the OSU Health Plan.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting:

The preparation of these consolidated financial statements is in conformity with generally accepted accounting principles, accepted in the United States of America as prescribed by the Governmental Accounting Standards Board ("GASB"). The System has the option of applying pronouncements issued by the Financial Accounting Standard Board ("FASB") after November 30, 1989, provided that such pronouncements do not conflict or contradict GASB pronouncements. The System has elected not to apply any FASB pronouncements after the applicable date.

The consolidated financial statements of the System have been prepared on the accrual basis of accounting. Revenues are recognized when earned and expenses are recorded when an obligation has been incurred. The System reports as a special purpose government entity engaged primarily in business type activities, as defined by GASB. Business type activities are those that are financed in whole or in part by fees charged to external parties for goods or services.

Certain amounts have been reclassified from the prior year to conform to the current year presentation. These reclassifications had no material impact on the previously reported consolidated statement of net assets.

New Accounting Pronouncements:

In November 2010, GASB issued Statement No. 60, *Accounting and Reporting for Service Concession Arrangements.* This standard provides guidance on accounting for agreements where a government transfers the right to operate a government asset to another entity, in exchange for significant consideration from that entity. Upfront payments from such agreements are to be recorded as a "deferred inflow of resources" and recognized as revenue over the life of the agreement. The standard also provides guidance for operators/concessionaires that are government entities. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2011.

Also in November 2010, the GASB issued Statement No. 61, *The Financial Reporting Entity: Omnibus (an amendment of GASB Statements No. 14 and No. 34)*. This Statement modifies certain requirements for inclusion of component units in the financial reporting entity. For organizations that previously were required to be included as component units by meeting the fiscal dependency criterion, a financial benefit or burden relationship also would need to be present between the primary government and that organization for it to be included in the reporting entity as a component unit. Further, for organizations that do not meet the financial accountability criteria for inclusion as component units but that, nevertheless,

should be included because the primary government's management determines that it would be misleading to exclude them, this Statement clarifies the manner in which that determination should be made and the types of relationships that generally should be considered in making the determination. This Statement also amends the criteria for reporting component units as if they were part of the primary government (that is, blending) in certain circumstances. The requirements of this Statement are effective for financial statements for periods beginning after June 15, 2012.

In December 2010, GASB issued Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*. This Statement incorporates into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in the following pronouncements issued on or before November 30, 1989, which does not conflict with or contradict GASB pronouncements:

1. Financial Accounting Standards Board (FASB) Statements and Interpretations

2. Accounting Principles Board Opinions

3. Accounting Research Bulletins of the American Institute of Certified Public Accountants' (AICPA) Committee on Accounting Procedure.

In addition, this Statement eliminates the option, provided under GASB 20, to elect to apply non-conflicting post-1989 FASB standards. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2011.

In June 2011, the GASB issued Statement No. 63*, Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*. This Statement provides financial reporting guidance for deferred outflows of resources and deferred inflows of resources. Concepts Statement No. 4, Elements of Financial Statements, introduced and defined those elements as a consumption of net assets by the government that is applicable to a future reporting period, and an acquisition of net assets by the government that is applicable to a future reporting period, respectively. Previous financial reporting standards do not include guidance for reporting those financial statement elements, which are distinct from assets and liabilities. *Concepts Statement 4* also identifies net position as the residual of all other elements presented in a statement of financial position. This Statement amends the net asset reporting requirements in Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments,* and other pronouncements by incorporating deferred outflows of resources and deferred inflows of resources into the definitions of the required components of the residual measure and by renaming that measure as net position, rather than net assets. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2011.

In March 2012, the GASB issued Statement No. 65, *Items Previously Reported as Assets and Liabilities*. This Statement establishes accounting and financial reporting standards that reclassify, as deferred outflows of resources or deferred inflows of resources, certain items that were previously reported as assets and liabilities and recognizes, as outflows of resources or inflows of resources, certain items that were previously reported as assets and liabilities. This Statement also provides other financial reporting guidance related to the impact of the financial statement elements deferred outflows of resources and deferred inflows of resources, such as changes in the determination of the major fund calculations and limiting the use of the term ‘deferred’ in financial statement presentations. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2012.

Also in March 2012, the GASB issued Statement No. 66, *Technical Corrections -- 2012*. This Statement resolves conflicting guidance that resulted from the issuance of two pronouncements, Statements No. 54, *Fund Balance Reporting and Governmental Fund Type Definitions*, and No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*. This Statement amends Statement No. 10, *Accounting and Financial Reporting for Risk Financing and*

Related Insurance Issues, by removing the provision that limits fund-based reporting of an entity's risk financing activities to the general fund and the internal service fund type. This Statement also amends Statement 62 by modifying the specific guidance on accounting for certain operating lease payments, purchases of loans and mortgage loan servicing fees. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2012.

In June 2012, the GASB issued two related accounting standards, Statement No. 67, *Financial Reporting for Pension Plans*, and Statement No. 68, *Accounting and Financial Reporting for Pensions*. Statement No. 67 builds upon the existing framework for financial reports of defined benefit pension plans and expands required note disclosures and Required Supplementary Information. It is effective for periods beginning after June 15, 2013.

Statement No. 68 requires governments that participate in defined benefit pension plans to report in their statement of net position (currently known as the statement of net assets) a net pension liability, which is the difference between the total pension liability and the assets set aside to pay pension benefits. Statement No. 68 also requires cost-sharing employers to record a liability and expense equal to their proportionate share of the collective net pension liability and expense for the cost-sharing plan. It is effective for periods beginning after June 15, 2014.

Health System management is currently assessing the impact that implementation of GASB Statements No. 60, 61, 62, 63, 65, 66, 67 and 68 will have on the Health System's financial statements.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires that management make estimates and assumptions regarding the reported amounts. The most significant areas requiring estimates relate to uncollectibles for accounts receivable, settlement liabilities with third party payors, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

In particular, laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs could change by a material amount in the near term.

Principles of Consolidation:

The consolidated financial statements include the accounts of the Health System and all wholly owned subsidiaries and controlled entities. All material inter-company transactions and account balances have been eliminated in consolidating the financial statements.

Net Assets:

Net assets are categorized as:

- Invested in capital assets, net of related debt: Capital assets, net of accumulated depreciation and outstanding principal balances of debt attributable to the acquisition, construction or improvement of those assets.

- Restricted:
  Nonexpendable – Net assets subject to externally imposed stipulations that they be maintained permanently.

Expendable – Net assets whose use by the Health System is subject to externally imposed stipulations that can be fulfilled by actions of the Health System pursuant to those stipulations or that expire by the passage of time.

- Unrestricted: Net assets that are not subject to externally imposed stipulations. Unrestricted net assets may be designated for specific purposes by action of management or the Board of Trustees or may otherwise be limited by contractual agreements with outside parties.

Cash and Cash Equivalents on Deposit with the University:

Cash and cash equivalents of $154,203 at June 30, 2012 and $151,526 at June 30, 2011 consist primarily of petty cash, demand deposit accounts, money market accounts, and savings accounts held at the University. Health System cash is pooled with other operating units within the University and earns interest income at rates established through the University's internal bank program.

Patient Accounts Receivable and Estimated Payables to Third-Party Payors:

A substantial portion of the System's revenue is received under contractual arrangements with Medicare and Medicaid. Payments from these payors are based on a combination of prospectively determined rates and retrospectively settled amounts. Many of the payment calculations require the use of estimates. Final settlement of the amount due to the System or payable to the payors are subject to the laws and regulations governing the federal and state programs and post-payment audits, which may result in further adjustments by the payors. Provisions for anticipated adjustments have been made in the financial statements. Certain adjustments made by third parties in previously settled cost reports are being appealed. Recoveries are recognized in the financial statements as adjustments to prior year settlements at the time the appeals are resolved.

The Health System also enters into contractual relationships with managed care organizations and other third party payors to provide services to plan beneficiaries. These relationships may include services provided to Medicare beneficiaries under Medicare Advantage programs and to Medicaid beneficiaries under Medicaid Managed Care programs. Many of the agreements with Medicare, Medicaid, and third-party payors provide for payment at amounts different from established prices. A summary of the significant payment arrangements with major third-party payors is as follows:

Medicare:

The Medicare program reimburses the System for services provided to its beneficiaries. The Ohio State University Hospital, The Richard M. Ross Heart Hospital, and The Ohio State University Hospital East reimbursement for inpatient services are based on a prospective payment system (PPS) that utilizes Medicare Severity Diagnostic Related Groups (MSDRGs). These payment rates vary according to the patient classification system established by the Center for Medicare and Medicaid Services (CMS). OSU Harding is paid under PPS for Medicare Inpatient Psychiatric facilities. Medicare reimburses the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute on a reasonable cost basis, subject to certain limits. Outpatient services for all business units are paid prospectively on pre-determined fee schedules or Ambulatory Payment Classifications (APCs). Costs of Graduate Medical Education, Paramedical training costs, and Transplant costs are reimbursed outside of MSDRGs on a combination of prospective and cost based methodologies. Reimbursement for these items is made at a tentative rate with a final settlement determined after submission of annual cost reports by the Health System, and audits thereof, by Medicare.

Medicaid:

Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge for every business unit except the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, which is reimbursed on a reasonable cost basis. These rates vary

according to a patient classification system that is based on clinical, diagnostic, and other factors. Outpatient services are paid prospectively on pre-determined fee schedules except the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, which is paid on a reasonable cost basis. Inpatient capital costs are paid based on a reasonable cost basis. The Health System is reimbursed for cost reimbursable items at tentative interim rates with final settlement determined after submission of annual cost reports by the Health System, and audits thereof, by Medicaid.

Other:

The Health System has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basic payment to the Health System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Settlements:

The Health System has estimated and recorded settlement amounts for all unsettled Medicare and Medicaid cost reports through June 30, 2012. In the opinion of Management, adequate provisions have been made for such settlements. The Health System records changes in estimates upon receiving interim or final settlements related to prior year cost reports. The most recent settled cost report for The Ohio State University Hospital for both Medicare and Medicaid was fiscal year ended June 30, 2007. The most recent settled cost report for the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute for Medicare was fiscal year ended June 30, 2008 and June 30, 2007 for Medicaid.

Contributions and Pledges Receivable:

The University receives pledges and bequests of financial support from corporations, foundations and individuals, including amounts relating to the capital expansion and patient care activities of the Health System. Contributions and pledges receivable have been recorded in the Health System's consolidated financial statements beginning in fiscal year 2012 based upon the concurrent determination that the underlying activities are to be recorded by the Health System. Revenue is recognized when a pledge representing an unconditional promise to pay is received and all eligibility requirements have been met. In the absence of such promise, revenue is recognized when the gift is received. Property contributions received in the current year totaled $ 4,569 and are recorded in Contributions for property acquisitions within Other Changes in Net Assets. Property contributions received by the University in prior years relating to the Health System's capital expansion project totaled $24,763 and have been recorded as Transfers of contributions for property acquisitions in the current year.

Pledges receivable are reported net of an allowance for uncollectable pledges of $352 at June 30, 2012 as estimated by management. In accordance with GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions*, endowment pledges are not recorded as assets until the related gift is received.

Inventories:

Inventories for the Health System consist primarily of pharmaceutical and operating supplies, and are valued at the lower of cost or market, with the cost determined on a FIFO (first-in/ first-out) basis.

Assets Whose Use is Limited:

Assets Whose Use is Limited are set aside for future capital improvements, third party settlements, debt repayments and research initiatives. Control of these assets is maintained by the Health System who may at its discretion subsequently use the assets for other purposes with Medical Center Board of Directors' approval.

These funds are invested in The Ohio State University Investment Pool and are recorded at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. The Health System receives interest based on rates established by The University's internal bank program.

The University's investment policy authorizes the University to invest non-endowment funds in the following investments:

- Obligations of the US Treasury and other federal agencies and instrumentalities
- Municipal and state bonds
- Certificates of deposit
- Repurchase agreements
- Mutual funds and mutual fund pools
- Money market funds

University Held Funds includes bond proceeds for the Medical Center Expansion Project of $27,247 and $155,606 for the fiscal years ending June 30, 2012 and 2011, respectively.

Endowment Funds:

All University endowments are invested in the University's long term investment pool and are invested and administered according to University policy. Certain endowment fund assets, namely funds relating to the Health System capital expansion and patient care activities, have been recorded in the Health System's consolidated financial statements beginning in fiscal year 2012 based upon the concurrent determination that the underlying activities are to be recorded by the Health System. Each named Health System fund is assigned a number of shares in the University long term investment pool based on the value of the gifts, income to principal transfers, or transfers of operating funds to the named fund. Annual distributions from the funds are computed using the share method of accounting for pooled investments. Health System endowment fund assets of $3,782 are included in Long term receivables and other assets on the Statement of Net Assets, which relates to prior periods net of current year investment changes.

Investments in Subsidiaries:

Investments in uncontrolled subsidiaries are recorded using the equity method of accounting.

Capital Assets:

Capital asset acquisitions are recorded at cost or at fair value at date of donation. Depreciation is recorded on a straight-line basis over the estimated useful life of the assets. The life of buildings range from 5-40 years, for equipment the range is 2-20 years, and for leasehold improvements the range is 3-16 years. The Health System uses guidelines established by the American Hospital Association to assign estimated useful lives to fixed equipment and inventoried equipment. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Long-lived assets are evaluated for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from future estimated cash flows. Fair value estimates are derived from independent appraisals, established market values of comparable assets or internal calculations of future estimated cash flows.

(in thousands)

Net Patient Service Revenues:

Patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated and retroactive settlements. Net patient service revenue for the year ended June 30, 2012 is summarized as follows:

Total patient service revenue	$ 6,080,771
Contractual allowances and other discounts	(4,135,839)
Provision for bad debts	(90,212)
Net patient service revenue	$ 1,854,720

Charity Care:

The Health System provides medical care to all patients regardless of their ability to pay. In addition, the Health System provides services intended to benefit the poor and under-served, the uninsured and the under-insured. Because the Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues or patient accounts receivable.

The total cost of charity care provided in fiscal year 2012 was $61,491 using a ratio of costs to gross charges calculation methodology. Net cost of charity care was reduced to $38,482 after applying $23,009 of support received under the Health Care Assurance Program (HCAP). HCAP is administered by the State of Ohio to help hospitals cover a portion of the costs of providing charity care.

Estimated Medical Liability Costs

The Health System recognizes medical liability contributions paid to The University's Self Insurance Program as a period expense. See NOTE 6 - SELF INSURANCE PROGRAM – MEDICAL LIABILITY.

NOTE 3 – CAPITAL ASSETS

Capital assets activity for the years ended June 30, 2012 and 2011 is summarized as follows:

	2012			
	Beginning Balance	Additions	Retirements and Reductions	Ending Balance
Land and Improvements	$ 24,268	550	2	$ 24,816
Buildings	377,806	30,396	62	408,140
Leasehold Improvements	21,573	923	-	22,496
Equipment - fixed	246,409	3,479	76	249,812
Equipment - moveable	359,277	72,655	7,885	424,047
Construction in progress	245,481	171,169	-	416,650
	1,274,814	279,172	8,025	1,545,961
Less accumulated depreciation	613,452	75,984	7,876	681,560
Capital assets, net	$ 661,362	203,188	149	$ 864,401

The increase in construction in progress of $171,169 in fiscal year 2012 represents capital expenditures of $279,172 (including capitalized interest of $16,623), net of capital assets placed in service of $108,003.

(in thousands)

	2011			
	Beginning Balance	Additions	Retirements and Reductions	Ending Balance
Land and Improvements	$ 23,634	634	-	$ 24,268
Buildings	367,953	9,853	-	377,806
Leasehold Improvements	21,110	463	-	21,573
Equipment - fixed	244,361	2,048	-	246,409
Equipment - moveable	340,109	40,062	20,894	359,277
Construction in progress	85,123	160,358	-	245,481
	1,082,290	213,418	20,894	1,274,814
Less accumulated depreciation	563,299	69,828	19,675	613,452
Capital assets, net	$ 518,991	143,590	1,219	$ 661,362

The increase in construction in progress of $160,358 in fiscal year 2011 represents capital expenditures of $213,418 (including capitalized interest of $11,052), net of capital assets placed in service of $53,060.

NOTE 4 – LONG-TERM DEBT

Long-term debt activity for the year ended June 30, 2012 is summarized as follows:

	Beginning Balance	Additions	Reductions	Ending Balance
University Bonds:				
2010, 4.95% through 2030	$ 298,452	$ 37,500	$ 10,259	$ 325,693
2008, 3.83%-4.03% through 2029	73,710		2,963	70,747
2005, 3.83%-4.03% through 2026	68,236		3,634	64,602
2003, 4.32%-4.57% through 2024	42,809		3,269	39,540
1999, 5.14% through 2030	6,940		287	6,653
1992, 6.30% through 2012	3,038		2,005	1,033
Other Financing:				
2012, 2.25%-4.00% through 2019		11,683	3,212	8,471
2010, 3.65%-5.84% through 2021	22,439		3,724	18,715
2009, 2.06%-5.26% through 2014	4,769		1,717	3,052
2008, 2.84%-4.00% through 2013	2,975		1,621	1,354
2007, 2.81%-4.05% through 2013	3,834		2,573	1,261
Interim financing provided by the University	265	4,740		5,005
Total Long Term Obligations	**527,467**	**53,923**	**35,264**	**546,126**
Less Current Portion of Long-Term Debt	32,546	34,467	32,546	34,467
Net Long Term Debt	**$ 494,921**	**$ 19,456**	**$ 2,718**	**$ 511,659**

(in thousands)

Long-term debt activity for the year ended June 30, 2011 is summarized as follows:

	Beginning Balance	Additions	Reductions	Ending Balance
University Bonds:				
2010, 4.95% through 2030	$0	$304,500	$6,048	$298,452
2008, 3.83%-4.03% through 2029	76,555		2,845	73,710
2005, 3.83%-4.03% through 2026	71,725		3,489	68,236
2003, 4.32%-4.57% through 2024	45,937		3,128	42,809
1999, 5.14% through 2030	7,220		280	6,940
1992, 6.30% through 2012	4,772		1,734	3,038
Other Financing:				
2010, 3.65%-5.84% through 2021	0	24,316	1,877	22,439
2009, 2.06%-5.26% through 2014	7,222		2,453	4,769
2008, 2.84%-4.00% through 2013	4,579		1,604	2,975
2007, 2.81%-4.05% through 2013	9,494		5,660	3,834
Interim financing provided by the University	41,138		40,873	265
Total Long Term Obligations	**268,642**	**328,816**	**69,991**	**527,467**
Less Current Portion of Long-Term Debt	21,354	32,546	21,354	32,546
Net Long Term Debt	**$247,288**	**$296,270**	**$48,637**	**$494,921**

University Bonds

The University has issued general receipts bonds, and has allocated a portion of those to the Health System through Memorandums of Understanding (MOUs) with no premium or discount on the debt. In fiscal year ended June 30, 2011, the Health System accessed $304,500 of the University's 2010 bond issue under an MOU. In 2012 an additional $37,500 was added to the MOU. The 2010 bonds have a term of 20 years at a rate of 4.95%. The purpose of this debt is the continued funding of the Medical Center Expansion project currently underway.

Other Financing

The University maintains an Internal Bank financing program through which it loans funds to operating units of the University. The Health System signs MOUs payable to the University for these borrowings.

During fiscal year 2012, the Health System received $5,280 at a rate of 2.25% for a term of 5 years to finance the purchase of medical equipment. Debt of $6,403 at 4.00% for two years was obtained through vendor financings, primarily for the implementation of a new integrated healthcare information system during the fiscal year. Additional interim financings from the University totaling $4,740 at 4.50% for 8 years were mainly used for facility renovation and equipment purchases required for the start up of CarePoint East.

During fiscal year 2011, the Health System received $8,400 from the University to purchase the Veteran's Administration facility, which became CarePoint East, at a rate of 4.50% for 10 years. Additionally, MOUs of $15,916 with the University were signed for equipment purchases and the start-up of the Eye & Ear Institute and CarePoint Gahanna.

Scheduled principal and interest payments on long-term debt based on scheduled maturities for the next five years and in subsequent five year periods are as follows:

(in thousands)

	Principal	Interest	Total
2013	34,467	24,516	58,983
2014	30,527	23,114	53,641
2015	29,648	21,787	51,435
2016	29,222	20,470	49,692
2017	28,761	19,189	47,950
2018-2022	149,122	75,781	224,903
2023-2027	151,663	40,185	191,848
2028-2032	92,716	7,559	100,275
	$ 546,126	$232,601	$ 778,727

NOTE 5 – OPERATING LEASES

The Health System leases various buildings, office space, and equipment under operating lease agreements. These facilities and items are not recorded as assets on the statement of net assets. Total operating lease and rental expense for fiscal year 2012 was $23,100.

The following is a schedule for the next five years and in subsequent five year periods of future minimum lease payments under operating leases as of June 30, 2012, that have initial or remaining lease terms in excess of one year:

2013	$12,692
2014	10,852
2015	10,498
2016	8,483
2017	8,262
2018-2022	32,777
2023-2027	16,461
2028-2032	12,136
	$ 112,161

NOTE 6 - SELF INSURANCE PROGRAM – MEDICAL LIABILITY

On July 1, 2003, the Health System joined with OSU Physicians (OSUP), a consolidating organization within The Ohio State University to establish a self-insurance fund for professional liability claims (Fund II), covering the hospitals as well as the physicians of OSUP. Previous to July 1, 2003, the Health System was self insured through the University for professional and general liability (Fund I). The assets and liabilities of both funds are consolidated in the University's financial statements, but are not included in the Health System consolidated financial statements, as a result of the retained risk being held by the University. Annual contributions to the fund(s) are actuarially determined and recorded as period expenses. The FY2012 medical liability expense for the Health System totaled $2,938.

The University has also established a pure captive insurer (Oval Limited) that provides excess coverage over both Fund I and Fund II. Both funds have retention of $4 million per occurrence. Unique to Fund II is aggregate loss of $14 million per fiscal year, 2010; 2011; 2012; and 2013. Oval Limited covers up to $55 million per occurrence with a $55 million annual aggregate limit. A portion of the risk written to date is reinsured by a combination of three reinsurance companies rated A by A. M. Best. Oval Limited's net retention is 50% of the first $15 million and 0% for the remaining $40 million per occurrence.

(in thousands)

Oval Limited assets and liabilities are consolidated in the University's financial statements, but are not included in the Health System consolidated financial statements, as a result of the retained risk being held by the University. Annual contributions from the Health System are recorded as period expenses and totaled $4,476.

There have been no settlements in the past three fiscal years which have exceeded the coverage provided by Fund I, Fund II, or Oval Limited. The Health System has not made any additional contributions in the last three years beyond its actuarially determined and Self Insurance Board approved premiums.

NOTE 7 - RETIREMENT PLANS

Health System employees, as part of The Ohio State University, are covered by one of three retirement systems. The University faculty is covered by the State Teachers Retirement System of Ohio (STRS Ohio). Substantially all other employees are covered by the Public Employees Retirement System of Ohio (OPERS). Employees may opt out of STRS Ohio and OPERS and participate in the Alternative Retirement Plan (ARP) if they meet certain eligibility requirements.

The Health System has no assets or liabilities of STRS Ohio, OPERS, or ARP included in its financial statements. Employer contributions to the plans by the Health System for its employees are included as a benefit expense in its statement of revenues, expenses, and changes in net assets.

STRS Ohio and OPERS each offer three separate plans: 1) a defined benefit plan, 2) a defined contribution plan and 3) a combined plan. Each of these three options is discussed in greater detail in the following sections.

Defined Benefit Plans

STRS Ohio and OPERS offer statewide cost-sharing multiple-employer defined benefit pension plans. STRS Ohio and OPERS provide retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. Benefits are established by state statute and are calculated using formulas that include years of service and final average salary as factors. Both STRS Ohio and OPERS issue separate, publicly available financial reports that include financial statements and required supplemental information. These reports may be obtained by contacting the two organizations.

STRS Ohio	OPERS, Attn: Finance Director
275 East Broad Street	277 East Town Street
Columbus, OH 43215-3371	Columbus, OH 43215-4642
(614) 227-4090	(614) 222-5601
(888) 227-7877	(800) 222-7377
www.strsoh.org	www.opers.org/investments/cafr.shtml

In addition to the retirement benefits described above, STRS Ohio and OPERS provide postemployment health care benefits.

OPERS currently provides postemployment health care benefits to retirees with ten or more years of qualifying service credit. These benefits are advance-funded on an actuarially determined basis and are financed through employer contributions and investment earnings. OPERS determines the amount, if any, of the associated health care costs that will be absorbed by OPERS. Under the Ohio Revised Code (ORC), funding for medical costs paid from the funds of OPERS is included in the employer contribution rate. For calendar year 2011, OPERS allocated 4.0% of the employer contribution rate to fund the health care program for retirees, and this rate was expected to remain the same for calendar year 2012 as of March 2012.

On September 9, 2004, the OPERS Retirement Board adopted a Health Care Preservation Plan (HCPP) with an effective date of January 1, 2007. In response to increasing health care costs, the HCPP restructured OPERS' health care coverage to improve the financial solvency of the fund by creating a separate investment pool for health care assets.

Under the HCPP, retirees eligible for health care coverage will receive a graded monthly allocation based on their years of service at retirement. HCPP incorporates a cafeteria approach, offering a broad range of health care options which allows benefit recipients to use their monthly allocation to purchase health care coverage customized to meet their individual needs. If the monthly allocation exceeds the cost of the options selected, the excess is deposited into a Retiree Medical Account that can be used to fund future health care expenses.

STRS Ohio currently provides access to health care coverage to retirees who participated in the deferred benefit or combined plans and their dependents. Coverage under the current program includes hospitalization, physicians' fees, prescription drugs, and partial reimbursement of monthly Medicare Part B premiums. Pursuant to ORC, STRS Ohio has discretionary authority over how much, if any, of the associated health care costs will be absorbed by STRS Ohio. All benefit recipients pay a portion of the health care cost in the form of monthly premiums. Under ORC, medical costs paid from the funds of STRS Ohio are included in the employer contribution rate. For the fiscal year ended June 30, 2011, STRS Ohio allocated employer contributions equal to 1.0% of covered payroll to a Health Care Stabilization Fund (HCSF) from which payments for health care benefits are paid.

Postemployment health care benefits are not guaranteed by ORC to be covered under either OPERS or STRS Ohio defined benefit plans.

Defined Contribution Plans

ARP is a defined contribution pension plan. Full-time administrative and professional staff and faculty may choose enrollment in ARP in lieu of OPERS or STRS Ohio. Classified civil service employees hired on or after August 1, 2005 are also eligible to participate in ARP. ARP does not provide disability benefits, annual cost-of-living adjustments, postretirement health care benefits or death benefits to plan members and beneficiaries. Benefits are entirely dependent on the sum of contributions and investment returns earned by each participant's choice of investment options.

OPERS also offers a defined contribution plan, the Member-Directed Plan (MD). The MD plan does not provide disability benefits, annual cost-of-living adjustments, postretirement health care benefits or death benefits to plan members and beneficiaries. Benefits are entirely dependent on the sum of contributions and investment returns earned by each participant's choice of investment options.

STRS Ohio also offers a defined contribution plan in addition to its long established defined benefit plan. All employee contributions and employer contributions at a rate of 10.5% are placed in an investment account directed by the employee. Disability benefits are limited to the employee's account balance. Employees electing the defined contribution plan receive no postretirement health care benefits.

Combined Plans

STRS Ohio offers a combined plan with features of both a defined contribution plan and a defined benefit plan. In the combined plan, employee contributions are invested in self directed investments, and the employer contribution is used to fund a reduced defined benefit. Employees electing the combined plan receive postretirement health care benefits.

OPERS also offers a combined plan. This is a cost-sharing multiple-employer defined benefit plan that has elements of both a defined benefit and defined contribution plan. In the combined plan, employee contributions are invested in self directed investments, and the employer contribution is used to fund a

(in thousands)

reduced defined benefit. Employees electing the combined plan receive postretirement health care benefits. OPERS provides retirement, disability, survivor and postretirement health benefits to qualifying members of the combined plan.

OPERS currently provides postemployment health care benefits to retirees with ten or more years of qualifying service credit. These benefits are advance-funded on an actuarially determined basis and are financed through employer contributions and investment earnings. OPERS determines the amount, if any, of the associated health care costs that will be absorbed by OPERS. Under Ohio Revised Code (ORC), funding for medical costs paid from the funds of OPERS is included in the employer contribution rate. For calendar year 2011, OPERS allocated 6.05% of the employer contribution rate to fund the health care program for retirees, and this rate was expected to remain the same for calendar year 2012 as of March 2012.

Funding Policy

ORC provides STRS Ohio and OPERS statutory authority to set employee and employer contributions. Contributions equal to those required by STRS Ohio and OPERS are required for ARP. For employees enrolling in ARP, ORC requires a portion (which may be revised pursuant to periodic actuarial studies) of the employer contribution be contributed to STRS Ohio and OPERS to enhance the stability of these plans. The required contribution rates (as a percentage of covered payroll) for plan members and the University are as follows:

	STRS Ohio	OPERS	ARP
Faculty:			
Plan member (entire year)	10.00%		10.00%
university (entire year)	14.00%		14.00%*
Staff:			
Plan member (entire year)		10.00%	10.00%
university (entire year)		14.00%	14.00%**
Law Enforcement:			
Plan member (7/11 - 12/11)		11.60%	11.60%
Plan member (1/12 - 6/12)		12.10%	12.10%
university (entire year)		18.10%	17.33%**

* Employer contributions include 3.5% paid to STRS Ohio.
** Employer contributions include .77% paid to OPERS.
The remaining amount is credited to employee's ARP account.

The University's contributions, including the Health System's, which represent 100% of required employer contributions, for the year ended June 30, 2012 and for each of the two preceding years are as follows:

Year Ended June 30,	STRS Ohio Annual Required Contribution	OPERS Annual Required Contribution	ARP Annual Required Contribution
2010	$52,500	$141,815	$39,014
2011	$54,725	$148,120	$40,835
2012	$58,006	$153,118	$43,523

(in thousands)

NOTE 8 – COMPENSATED ABSENCES

Health System employees earn vacation and sick leave on a monthly basis. Classified civil service employees may accrue vacation benefits up to a maximum of three years credit. Administrative and professional staff and faculty may accrue vacation benefits up to a maximum of 240 hours. For all classes of employees, any earned but unused vacation benefit is payable upon termination.

Certain employees (primarily classified civic service) may receive compensatory time in lieu of overtime pay. Any unused compensatory time must be paid to the employee at the time of termination or retirement.

Sick leave may be accrued without limit. However, earned but unused sick leave benefits are payable only upon retirement from the University with ten or more years of service with the State. The amount of sick leave benefit payable at retirement is one fourth of the value of the accrued but unused sick leave up to a maximum of 240 hours.

The Health System accrues sick leave liability for those employees who are currently eligible to receive termination payments as well as other employees who are expected to become eligible to receive such payments. This liability is calculated using the "termination payment method" which is set forth in Appendix C, Example 4 of the GASB Statement No. 16, *Accounting for Compensated Absences*. Under the termination method, the Health System calculates a ratio, Sick Leave Termination Cost per Year Worked, which is based on the Health System's actual historical experience of sick leave payouts to terminated employees. This ratio is then applied to the total years-of-service for current employees.

See the rollforward of compensated absences activity as included in Note 9.

NOTE 9 – OTHER LONG TERM LIABILITIES

Other long term liability activity for the years ending June 30, 2012 and 2011 is summarized as follows:

	2012			
	Beginnng Balance	Additions	Reductions	Ending Balance
Compensated absences	$ 44,245	6,741	1,937	$ 49,049
Third party payor settlements	44,328	-	26,971	17,357
Other long term liabilities	10,859	-	2,905	7,954
	99,432	6,741	31,813	74,360
Less current portion third-party payor settlements	15,489	-	11,848	3,641
Net other long term liabilities	$ 83,943	6,741	19,965	$ 70,719

(in thousands)

	2011			
	Beginnng Balance	Additions	Reductions	Ending Balance
Compensated absences	$ 40,056	6,819	2,630	$ 44,245
Third party payor settlements	44,694	-	366	44,328
Other long term liabilities	504	10,355	-	10,859
	85,254	17,174	2,996	99,432
Less current portion third-party payor settlements	18,278	-	2,789	15,489
Net other long term liabilities	$ 66,976	17,174	207	$ 83,943

NOTE 10 – CONCENTRATIONS OF CREDIT RISK

The Health System grants credit without collateral to its patients, most of whom are local residents and are insured under third party payor agreements. The mix of hospital accounts receivable from patients and third party payors at June 30, 2012 and 2011 is summarized as follows:

Payor - receivables	2012	2011
Medicare	20 %	19 %
Medicaid	14	15
Managed Care	59	57
Self Pay	7	9
Total	100 %	100 %

NOTE 11 – RELATED PARTY TRANSACTIONS

The Ohio State University

The Health System purchases employee benefits, utilities, mail services, and construction project management services from the University. Additionally, the Health System pays university overhead, which includes such services as payroll processing, public safety, auditing, and insurance. University overhead charged to the Health System was $43,046 for the year ended June 30, 2012 and is recorded in Other expenses.

OSU Physicians

The Health System leases the IDX patient management, accounting and billing software and related hardware to OSU Physicians, Inc. (OSUP). In conjunction with the implementation of a new integrated health information system, the Health System has recorded $3,700 in current receivables and $6,538 in long term receivables from OSUP to cover OSUP's share of the system's implementation and operating costs.

OSUP provides patient account management and billing services for the Health System based physician practices. The Health System also contracts with certain OSUP LLCs to provide physician services to some of the Health System based physician practices.

College of Medicine

The Health System transfers funds to the College of Medicine for support of programs and research which are recorded as Medical Center investments. Medical Center investments totaled $99,002 for fiscal year 2012 and is reflected as other changes in net assets.

NOTE 12 – CONTINGENCIES

The Health System is a party in a number of legal actions where the final outcome cannot be determined at this time. Except for the following matter, management is of the opinion that the liability, if any, for these legal actions will not have a material adverse effect on the Health System's future financial position, results of operations, or cash flows.

In June 2012, the Centers for Medicare and Medicaid Services (CMS) notified the Health System that its laboratory was out of compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 based on the findings of a March 2012 survey. During June 2012, the Health System filed an appeal in response to the possible sanction(s). The ultimate outcome of this matter could have a material impact to the Company's consolidated statement of net assets, statement of revenues, expenses and changes in net assets and/or statement of cash flows. At this time, there is inadequate information from which to estimate a potential range of liability, if any.

NOTE 13 - COMPLIANCE

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

The estimated Medicare and Medicaid cost report settlements recorded at June 30, 2012 could differ from actual settlements based upon results of the cost report audits discussed in Note 2. Changes in Medicare and Medicaid programs and the reduction of funding levels could have a material adverse impact on the Health System.

NOTE 14 - SUBSEQUENT EVENTS

The Health System evaluated subsequent events through November 9, 2012, the date the consolidated financial statements were issued. All material matters are disclosed in the footnotes to the consolidated financial statements.

Report of Independent Auditors on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To Board of Trustees of
The Ohio State University

We have audited the consolidated statements of net assets of The Ohio State University Health System (the "Health System") as of June 30, 2012, and the changes in financial position and cash flows for the year then ended June 30, 2012, and have issued our report thereon dated November 9, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America 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

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 over financial reporting 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*.

We noted certain matters that we reported to management of the Health System in a separate letter dated November 9, 2012.

This report is intended solely for the information and use of the Health System's management, the Board of Trustees, others within The Ohio State University, and the Ohio Auditor of State, and is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 9, 2012

Dave Yost • Auditor of State

THE OHIO STATE UNIVERSITY HEALTH SYSTEM

FRANKLIN COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
JANUARY 17, 2013

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