



February 9, 2017

BY EMAIL (erik.bodin@vdh.virginia.gov) ONLY

Mr. Erik O. Bodin, Director
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485

Re: Request for Additional Information – Response # 10

Dear Mr. Bodin,

Response # 10 to the questions received from your office on December 22, 2016, has been uploaded to the Citrix ShareFile platform.

Please contact me if you have any difficulty or questions in accessing the Citrix ShareFile platform. As permitted under Virginia Code § 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), the material that the parties believe to be proprietary is clearly marked and submitted in separate electronic files for confidential treatment.

Responses to the following questions are submitted as part of Response # 10:

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Additional responses will be provided as soon as possible. Please let me know if you or your staff has any questions related to the enclosed documents.

Sincerely,



Jennifer Light McGrath

cc: Peter Boswell
Allyson K. Tysinger

860600/1

Healthy Children and Families Steering Committee

Chairs

Dr. David Wood, Chair of Pediatrics, East Tennessee State University

Travis Staton, CEO, United Way of Southwest Virginia

Healthy Children and Families Steering Committee

Last Name	First Name	Organization	Title
Angelopoulos	Dr. Theodore (Ted)	Emory & Henry School of Health Sciences	Professor
Bailey	Dr. Beth	ETSU, Dept. of Family Medicine	Professor and Director of Research
Baker	Dr. Katie	ETSU, Dept. of Community & Behavioral Health	Assistant Professor
Beilharz	Lisa	Boys and Girls Club of Kingsport	Chief Professional Officer
Carter	Lisa	Niswonger Children's Hospital	CNO, Interim CEO
Casteel	Tommy	Virginia Department of Social Services	Regional Director
Castro	Dr. Sandra	Niswonger Children's Hospital	Pediatric Emergency Physician
Collins	Dr. Melinda	Milligan, School of Sciences & Allied Health	Associate Dean
DeVoe	Dr. Michael	ETSU Pediatrics	Director, Neonatology Professor and Vice Chair
Feierabend	Margaret	Bristol Promise; Bristol City Council Member	Chairman (Bristol Promise)
Gouge	Dr. Natasha	MSMG Pediatrics	PhD Licensed Clinical Psychologist
Hale	Dr. Kim	ETSU, College of Education	Associate Dean/ Early Childhood Education
Kozinetz	Dr. Claudia	ETSU, Public Health	Professor and Chair, Department of Biostatistics and Epidemiology
Mabrey	Gary	Washington County/ Johnson City/ Jonesborough Chamber of Commerce	President & CEO
Midgett	Linda	People Incorporated of Virginia	Director, Community Services
Montgomery	Paul	Northeast State	VP, Access & Development
Myers	Dr. Pam	Highlands Pediatrics	Pediatrician
Perry	Tim	Frontier Health	Director, Children's Outpatient Services
Polaha	Dr. Jodi	ETSU	Associate Professor Family Medicine
Powers	Catherine	ETSU	Professor of Nursing
Ratliff	Dr. Brian C.	Washington County Virginia Schools	Superintendent of Schools
Rhinehart	Beth	Bristol Chamber of Commerce	President /CEO
Schetzina	Dr. Karen	ETSU	Associate Professor, Pediatrics
Skinner	Glen "Skip"	LENOWISCO Planning District Commission	Executive Director
Smith	Dr. Michael	ETSU, Dept. of Social Work	Department Chair
Staton	Travis	United Way of Southwest Virginia	CEO
Stephens	Stephanie	Appalachian Association for the Education of Young Children	President
Teague	Donna	Johnson County Community Hospital	LPN
Terry	Kathlyn	Appalachian Sustainable Development	Executive Director
Thomas	Cynthia	TN Department of Health	Assistant Medical Director
Tipton	Lisa	Families Free	Executive Director
Wood	Dr. David	ETSU	Chair, Department of Pediatrics

EXECUTIVE SUMMARY

Healthy Children and Families Steering Committee

As one of the largest steering committees out of the four assembled for this project, the Healthy Children and Families Committee worked diligently and passionately toward setting priorities for improving the health of families in the region. The goal of the committee's work was to advocate for programs and services to support a resilient and healthy family environment in order to positively impact the life course of children. Specific objectives selected by the committee were to identify and promote effective programming to:

- Promote positive birth outcomes
- Optimize early childhood and school aged child development and school performance.
- Assure youth achieve their maximum potential and transition to post high-school education and work.

The committee recognized that the health of children and families are inseparable, and in order to ensure a healthy life course for children, health-related social needs must be addressed. These social needs include parental employment with a living wage, stable and adequate housing, access to transportation, and access to affordable healthy food, and safety from violence. The committee strongly felt that any model of regional health improvement and development should provide adequate supports for healthy family functioning, healthy child development, and promote optimal mental health in both children and their parents. To this end, we must promote widely child developmental, behavioral, and parental mental health screening, intervention, treatment, and recovery services, must be developed and implemented in local communities across the region.

Many of the families served by representative agencies on the committee live in economically depressed rural areas in which social factors such as poverty, unemployment, low educational attainment, and substance abuse are highly prevalent. Providing support services for high risk rural communities, as well as high risk urban communities, will require cross-sector collaborative approaches that are built on a foundation of local engagement and leadership. Associated with poverty and other measures of disadvantage, counties in Northeast Tennessee and Southwest Virginia have been burdened with some of the highest chronic disease rates in the nation, such as obesity, hypertension, drug addiction, cardiovascular disease, and cancer. In adulthood these diseases are largely related to the unhealthy behaviors common in our region such as: smoking, physical inactivity, poor nutrition, and alcohol/prescription drug use. These behaviors and health conditions, however, share common upstream causes rooted in children's adverse physical and emotional environment and subsequent social, emotional, and intellectual development.

To impact the generational health of the region, it is important to prevent the upstream causes by providing healthy and enriching environments for families and their children where they can be born, grow up, go to school, survive adolescence and enter the workplace. Simultaneously we have to offer evidenced-based programs that improve the health of children, youth, and families, and reduce unhealthy behaviors that exist in the region. What is presented herein is a set of priorities and evidence-based approaches to promote healthy child development and promote optimal outcomes for families in the region.

Priority areas

The committee held five meetings between September 8, 2015, and January 12, 2016, during which the focus was on developing a set of workable priorities that could be included as recommendations for improving health in the region. The committee went through a rigorous prioritization process to get down to a manageable set of items. The first step was to capture all possible priorities committee members felt should be included. Using an online survey tool, each member's ranked priority list was plugged into a calculation of the committee's priority ranking. The result of the process was a set of priority areas with specified processes and outcomes under each (43 in total) that represented the committee's priority for affecting child and family health (See Appendix II).

Using a weighting system to evaluate committee responses, individual rankings were applied to each of the 43 items to tease out the importance of each. Appendix II displays a graphic organizing these priority areas and prioritized outcomes. Once rankings were established, further discussion developed an operational framework that could address the priorities and ensure the committee's recommendations would be useful and comprehensive. It was decided to seat the priorities in the life course model as it relates to families and children. The result was three main categories listed below:

Recommended approaches

In order to address each objective, priorities were selected to serve as metrics or measures of success based on four criteria. Selected measures must meet the following criteria:

- Supported by best available evidence
- Top priority for the committee
- Aligned with Virginia and Tennessee state priorities
- Measurable

Below is a description of each of those measures of success along with contextual information regarding supporting evidence and regional practices if available. The committee agrees that these approaches are essential to ensure the health of children and families in the region.

I. Healthy start:

- A. Increase access to high-quality prenatal and postnatal care including new models of supportive prenatal care such as CenteringPregnancy
- B. Increase delivery of services to prevent alcohol, drug, and tobacco use in women of childbearing age
- C. Increase support for breastfeeding initiation and continuation

II. Ready to learn:

- A. Improve educational and social readiness of children under 5 in preparation to enter kindergarten through community wide measurement and interventions
- B. Increase access to affordable, high quality early education for all children including those with special needs
- C. Actively screen all children and families for psychosocial needs and provide accessible, family-based interventions
- D. Promote family strengths with increased access to in-home services that support child development and parenting
- E. Increase access to comprehensive and multi-specialty services for children with chronic conditions
- F. Increase access to dental screening and dental preventive care and restorative care
- G. Reduce hunger and food insecurity among expecting mothers and children.

III. Supported and empowered youth:

- A. Reduce teen pregnancy through increased access to evidenced-based pregnancy prevention education and long acting reversible contraception methods
- B. Increase the number of high school graduates pursuing postsecondary education or career training
- C. Provide services to reduce teen suicide and teen suicide attempts

I. Healthy Start

The following objectives were developed to meet the goal of encouraging positive birth outcomes and early childhood development.

A. Increase access to high-quality prenatal and postnatal care including new models of supportive prenatal care such as CenteringPregnancy

Problem Statement: Traditional prenatal care has not fully addressed the psychosocial needs of pregnant women. Innovative approaches are needed to help women have healthy pregnancies that result in optimum birth outcomes.

Evidence Statement: High quality prenatal care provides mothers the opportunity to ask questions about how they can maximize their own health and the health of their fetus throughout pregnancy. A recent study of innovative strategies to increase the quality of prenatal care in under resourced areas examined three dimensions: strategies to increase access to timely prenatal care, strategies to improve the content of prenatal care, and strategies to enhance the organization and delivery of prenatal care.¹

Researchers determined the following elements must be part of any effort to ensure access and utilization of quality prenatal care:

- Medicaid expansion for low-income women
- Data sharing to identify at-risk mothers
- Continuous quality improvement
- Implementation of “wraparound” prenatal services
- Rigorous program evaluation

One program that has shown promise is CenteringPregnancy, which takes patient-centered care a step further by bringing together groups of 6 to 10 women of similar gestational stage to meet for approximately two hours over the course of ten visits during their pregnancy and afterwards. Each session includes an individual health assessment (weight, blood pressure, etc.). The individual session is then followed by peer discussion covering various topics related to pregnancy and parenting.² Program impact and outcomes are measured through a data collection tool offered to providers called CenteringCounts. Private OB/Gyn practices and hospitals can be certified as CenteringPregnancy centers which requires specific training in curriculum design and group facilitation. Currently there are no certified CenteringPregnancy locations in Northeast Tennessee or Southwest Virginia. There are official CenteringPregnancy locations at the Lisa Ross Birth & Women's Center in Knoxville and the Cherokee Health Systems in Talbott, TN.

Some study has been done around CenteringPregnancy and its application in rural Appalachia, with mixed results. One study involving 29 women who declined to enroll in the program at a local birthing center suggested some potential barriers to uptake in this population.³ The clinic in this study was primarily utilized for low-risk pregnancies, but many women in the community

used it as a point of access for prenatal care. The most common reason given by women for not participating in the CenteringPregnancy program was fear of exposure through the group meetings. Women did not want to discuss their private issues in public.

Women also identified inconvenient meeting times, transportation, and needs of existing children as barriers to participation. These results indicate that implementation of the CenteringPregnancy program must include great emphasis on privacy. Program staff should also take care to separate the program from any association with mandatory counseling or drug rehab programs which also use the word “group” in reference to their meetings. Other barriers identified in the study (i.e. meeting hours, transportation and childcare) must be considered when choosing to implement the program.

Recommendation: Locally adapt and disseminate high quality prenatal and postnatal care including new models of supportive prenatal care such as CenteringPregnancy

B. Increase delivery of services to prevent or reduce alcohol, drug, and tobacco use in women of childbearing age

Problem statement: Alcohol and drug use among women of childbearing age is a major cause of birth defects and other poor birth outcomes including Neonatal Abstinence Syndrome (NAS).

Evidence Statement: To prevent alcohol and drug abuse in women of childbearing age (ages 15-45), the evidence indicates that prevention should start early, before 15 years of age. This approach helps children to make healthier choices and, therefore, have better health outcomes. In addition, the positive economic effects are supported by research that indicates for each dollar invested in evidence-based substance abuse prevention education, there is a return of approximately \$18.90.⁴ Primary prevention of substance abuse during adolescence lowers the risk of developing substance use disorder in adulthood. Nearly half of adults who report trying alcohol before age 14 become alcohol dependent later in life compared to 7-9% of those who wait until age 21 to drink.⁵

Best practices in substance abuse prevention suggest the most effective way to prevent drug abuse in communities is to offer consistent messaging from multiple arenas including schools, family, and community leaders.⁶ No matter where the program takes place, who or what should be culturally competent, developmentally appropriate, and focused on early intervention. Programs targeting elementary school-aged children should focus primarily on the following issues:⁶

- Self-control
- Emotional awareness
- Communication
- Social problem-solving

- Academic support

Programs for middle and high-school students should build on the curriculum offered in K-5 to additionally cover:⁶

- Peer relationships
- Self-efficacy and assertiveness
- Drug resistance skills
- Reinforcement of anti-drug attitudes
- Strengthening of personal commitments against drug abuse

On a larger scale, community programs typically focus on policy development and mass media campaigns. These programs can often be very effective when delivered during key “transition” points such as the transition from elementary to middle school. Guidelines targeting specific at-risk populations also benefit the entire community by creating an anti-drug culture and reduce stigma, thereby reducing overall drug and alcohol use and “shifting the population mean” on this behavior.

In addition to primary prevention efforts to reduce the prevalence of substance use disorder in the population, other methods that increase population screening and brief interventions in the adult population should also be considered in a comprehensive prevention strategy. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) system is used to prevent substance use disorder by assessing individual risk and offering education on how to mitigate it. SBIRT can be used at emergency room or primary care visits or in other settings (workplace wellness, schools, etc.) by asking a short set of screening questions that are an assessment of risk. A brief intervention by a physician or other personnel can follow with a referral to treatment for those willing to accept a referral.⁷

While SBIRT can serve to inform adults of their risk for substance use disorder based on their current use, there are some limitations associated with it. The success of referral depends on the availability of treatment options in proximity to the primary care facility. Uptake of the SBIRT tool by physicians and hospitals can be negatively affected by the lack of referral service so it will be important to focus on the regional behavioral health infrastructure when planning for the application of early intervention approaches in the adult population.

Recommendation: Increase delivery of services to prevent or reduce alcohol, drug, and tobacco use in children and women of childbearing age by focusing efforts on community wide media efforts, school-aged child focused prevention, and broader dissemination of evidenced based SBIRT programs.

c. Increase support for breastfeeding initiation and continuation

Problem Statement: Although breastfeeding is widely accepted as a best practice for new mothers, the prevalence in some areas remains quite low. In 2011 only 79.2% of mothers in the United States reported ever breastfeeding and only 49.4% reported breastfeeding until the recommended six month time point.⁸

The American Academy of Pediatrics recommends that infants should breastfeed exclusively until six months of age and should continue to breastfeed for a year and for as long as is mutually desired by the mother and baby.⁹ Tennessee lagged behind the national average in all measures including ever breastfeeding, breastfeeding at six months, breastfeeding at one year, and exclusively breastfeeding. Virginia was above the national average on most measures (Table 1).

Table 1. Percentage of mothers breastfeeding in the United States, 2011⁹

	Ever	@ 6 months	@ 12 months	Exclusive @ 3 months	Exclusive @ 6 months
United States	79.2	49.4	26.7	40.7	18.8
TN	74.9	40.7	20.9	39.1	15.4
VA	80.5	53.7	27.4	38.3	22.9

Evidence Statement: Infants who are breastfed on average experience lower rates of diarrhea, ear infections, lower respiratory tract infections, and are at lower risk of sudden infant death syndrome.¹⁰ As they grow older, breastfed babies have long term positive health effects such as reduced rates of diabetes, obesity, and behavioral health disorders. In addition to the benefits for baby, breastfeeding has also been shown to be a protective factor for women against breast cancer, ovarian cancer, and diabetes.¹⁰

Healthy People 2020 has cited breastfeeding as an important issue and four out of the five goals related to infant care are related to breastfeeding. The five goals are:¹¹

- Increase the proportion of infants who are put to sleep on their backs
- Increase the proportion of infants who are breastfed
- increase the proportion of employers that have worksite lactation support programs
- Reduce the proportion of breastfed newborns who receive formula supplementation with the first two days of life
- Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies

The state of Tennessee has also specifically identified four objectives related to breastfeeding in the 2010-2015 Nutrition and Physical Activity Plan including:¹²

- Promoting new and existing laws that support and protect breastfeeding both at work and in public
- Encouraging the adoption of activities that create breastfeeding-friendly communities like peer counseling and supporting the Loving Support WIC program
- Using media, social marketing resources, and public education to promote breastfeeding
- Researching and evaluating breastfeeding outcomes, quality of care, and best practices

Increasing breastfeeding initiation and continuation until the recommended time requires a multi-pronged approach.¹³ There is significant evidence to support the importance of competent and accessible clinical care and the initiation of breastfeeding. In 1991, the World Health Organization partnered with the United Nations Children's Fund (UNICEF) to create the Baby-Friendly Hospital Initiative. The initiative outlined ten concrete steps hospitals can take to optimize breastfeeding initiation and continuation among their patients. Research shows that implementation of these steps within hospitals and birthing facilities increases the rates of breastfeeding in the patient population.^{14,15,16} The ten steps to successful breastfeeding are:¹⁷

- 1) Have a written breastfeeding policy that is routinely communicated to all healthcare staff
- 2) Train all healthcare staff in skills necessary to implement this policy
- 3) Inform all pregnant women about the benefits and management of breastfeeding
- 4) Help mothers initiate breastfeeding within one hour of birth
- 5) Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants
- 6) Give newborn infants no food or drink other than breastmilk, unless medically indicated
- 7) Practice "rooming in"—allow mothers and infants to remain together 24 hours a day
- 8) Encourage breastfeeding on demand
- 9) Give no pacifiers or artificial nipples to breastfeeding infants
- 10) Foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or clinic.

Although there are hospitals in Tennessee and Virginia that have the Baby-Friendly designation, none are located in the Northeast Tennessee or Southwest Virginia region.¹⁸

With regard to continued support for breastfeeding mothers, peer support programs have been widely researched and shown to be effective at helping mothers continue breastfeeding until the recommended time. A 2012 Cochrane review examined whether providing extra support for breastfeeding mothers from professionals, trained lay workers, or both, could help mothers to continue breastfeeding.⁹ The research showed that support from health professionals and lay workers helped women continue breastfeeding. The findings also revealed that face-to-face interventions as opposed to telephone interventions appeared to be more effective to help women continue breastfeeding.

Programs that required the new mother to seek support were not as effective, rather ongoing and regularly scheduled visits or meetings to support breastfeeding helped women to continue longer.⁹ Peer support is a cost-effective approach and among groups with low breastfeeding rates, presents a way to break down barriers to support women and their infants.¹³ Many programs that incorporate individuals inside a woman's social network, such as the fathers and perhaps grandmothers, have also shown to help encourage women to breastfeed.¹³

Recommendation: Increase support for breastfeeding initiation and continuation through a multipronged approach that includes peer support, baby-friendly hospital initiatives, and social marketing.

Ready to Learn

The following objectives were developed to meet the goal of preparing children for success in school and supporting families of preschool and school aged children to provide a healthy school and family environment.

A. Improve educational and social readiness of children under 5 in preparation to enter kindergarten through community-wide measurement and interventions

Problem Statement: The environments in which children learn and develop, as well as the quality of their interactions with adults, have a significant impact on their cognitive, social, and emotional development. Children living in poverty enter kindergarten at risk for developmental delays and persistent academic failure.

Evidence Statement: Developmental screenings administered during early childhood years can describe how children are developing and predict educational, social, and health outcomes. Using data from developmental screenings to identify communities with children not ready for kindergarten enables community partners to match children and families to interventions through community engagement strategies. This community approach has been shown as a catalyst to improve developmental and social outcomes for children, including the most vulnerable children. Transforming Early Childhood Community Systems (TECCS) is one such program whose goal is to improve the physical well-being, social and emotional competence, and cognitive functioning of young children throughout a region by using developmental assessments of young children at a population level and mapping the accessibility of community services within the community.¹⁹ TECCS is a national partnership between the UCLA Center for Healthier Children, Families and Communities and the United Way Worldwide. TECCS uses the early development instrument (EDI) to assess five areas of child development that impact academic success, including: physical health; social competence; emotional maturity; language and cognitive development; communication skills; and general knowledge.¹⁹ EDI results are then reported out to inform community stakeholders identifying the need to enhance the quality and availability of services for young children and families in the communities where they are needed most.

Recommendation: Institute a developmental assessment program in all kindergarten classes in Northeast Tennessee and Southwest Virginia, and use data to determine community need for evidence based interventions to improve the social, emotional, cognitive, and health outcomes for children such as parenting education, home visiting programs, early literacy and math activities, and access to high quality child care and pre-kindergarten school.

B. Increase access to affordable, high-quality early education for all children including those with special needs

Problem Statement: A minority of poor or at-risk families with young children (0-5 years of age) in Northeast Tennessee and Southwest Virginia have access to high-quality early childhood education services.

Evidence Statement: Head Start is a federal program offered to low-income children from birth to age five. Short-term outcomes of children who participate in Head Start indicate improved test scores, language and literacy development, social-emotional development, health outcomes (due to availability of health insurance), and parent-child relationships.²⁰ Longer-term study of the Head Start program has found that there are sustained academic and social emotional benefits in adolescence and beyond.²¹ High-school students who participated in Head Start as children were less likely to be held back a grade, commit a crime, or become pregnant.²² In addition, adults who were participants in the Head Start program tend to have fewer convictions for crimes, higher high school (or equivalent) graduation rates, and higher GPA throughout schooling.

Studies have shown that access to high-quality early childhood education services can have a significantly positive impact on the cognitive and social development of children, improving academic performance in both early childhood through adolescence, and can reduce or eliminate the effect of socioeconomic disadvantage or inequity.²³ It appears the effect on brain development and subsequent academic performance is positive for any number of hours per week children spend in quality non-parental child care, but the impact is greatest in children spending 35 hours or more per week in child care. Equally important for infants and young children is the need to educate, mentor, and support families to provide safe and stimulating environments in the home through programs such as Nurturing Parenting, Family Works, Parenting Wisely, Reach out and Read, ReadNPlay, and Positive Parenting.²⁴

Agreement on the indicators of quality child care is not universal, nor are standards of licensure between states. The National Association for the Education of Young Children (NAEYC) suggests the following standards as a measure of quality in early childhood programs:

- positive relationships among all children and adults, and the establishment of collaborative relationships with families
- curriculum promoting learning and development in the areas of social and emotional functioning, gross and fine motor skills, language, and cognition
- teaching strategies that are developmentally, culturally, and linguistically appropriate and enhance children's learning
- developmental assessment of a child's growth, learning, and development
- quality environment which promotes nutrition, health, and safety of the child
- qualified teaching staff with educational qualifications, knowledge, and skills in child development and early childhood education

Offering high-quality early childhood education can be a challenge, particularly in rural communities across the US. Rural grantees of Head Start funding often

struggle to meet stringent Head Start program performance standards (HSPPS) due to lack of transportation and required medical, dental and mental health referral options for enrolled children. Due to lack of transportation, many Head Start centers also often lack the minimum enrollment required to offer Head Start services to the community. There is a dearth of professional development opportunities for licensed Head Start teachers, and many people trained in rural areas will then migrate to metro areas in search of higher salaries once they are licensed.

Spurred on by constraints in funding Head Start programs for transportation, some rural programs have built creative partnerships with other organizations in their area to overcome this challenge.²⁵ In order to meet the need for healthcare referrals, a Head Start grantee in Coffeyville, Kansas, collaborated with a local Federally Qualified Health Center (FQHC) to provide access to health services. The FQHC offers a portable dental clinic which helps the Head Start center to meet the requirements for dental health.²⁵ This type of collaboration between community-based entities and Head Start programs is essential in rural locations so they can meet the HSPPS requirements for their enrolled children.

Despite the challenges associated with being in rural locations, there are several Head Start programs throughout Northeast Tennessee and Southwest Virginia. The Upper East Tennessee Human Development Agency in Northeast Tennessee serves more than 1,000 children in eight counties including Hawkins, Johnson, Washington, Greene, Sullivan, Unicoi, Carter, and Hancock. In Southwest Virginia, Head Start programs are offered through public agencies (e.g. Lee County Public Schools) as well as nonprofit organizations (e.g. Kids Central, Inc.) in the following counties: Buchanan, Tazewell, Wise, Dickenson, Lee, Smyth, Wythe, Washington, Russell, Grayson, and Scott. However, despite the presence of these programs only a minority of children who need them are enrolled.

The Tennessee Department of Human Services applies similar measures in its rating of child care providers in the state. The state's Child Care Certificate program, which is funded through the federal Child Care and Development act, provides assistance to low-income families in need of child care services.²⁶ In Virginia, the CommonHelp assistance program, which provides eligible families with support for food security, child care, housing, and cash assistance, functions in much the same through funding from the Child Care and Development Act. Increased funding for these programs will make child care available to more families in the region, but transportation issues will have to be addressed as well if utilization is to increase.

The Healthy Start Tennessee program targets families at high risk of child abuse and/or neglect, as measured by the Kempe Family Stress Checklist. Healthy Start is currently offered in 20 counties through seven community-based agencies. Funding to support this program comes from the State of Tennessee with an annual cost per child of \$2,984. When compared to statewide populations, participants of Healthy Start do better in many important outcome measures (Tables 2, 3, and 4).

Recommendation: Provide universal access to high-quality early childhood education and child care for all families whose children are at risk for poor school readiness and school failure.

C. Actively screen all children and families for psychosocial needs and provide accessible, family-based interventions

Problem Statement: The presence of psychosocial concerns in childhood are demonstrated risk factors for a series of poor outcomes in late childhood, adolescence, and adulthood including poor academic performance, depression, antisocial behavior, and substance abuse.²⁷ These concerns are of growing societal significance, with rates of adolescent mental health problems, especially conduct disorders and depression, increasing across recent decades in Western societies.²⁸ In a cross-temporal analysis of the MMPI, Twenge et al. showed young adult psychopathology has increased by one standard deviation in most problem scores over the past 70 years.²⁹

Over the last four decades, evidence-based treatments (EBTs) have been developed that can disrupt or prevent consequences associated with early psychosocial concerns.^{29,30} However, these treatments are not reaching many of the children who need them. First, significant barriers to care such as cost, provider shortages, and long waiting lists for services have been identified. Estimates show 4 out of 5 children ages 6-17 with psychosocial problems do not receive any help.³¹ Secondly, even when families do access mental health services, they are not likely to get an EBT.^{32,33} Several studies have shown community-based mental health clinicians have not adopted EBTs into their practice, relying on clinical judgment instead.^{34,35,36} Finally, studies of consumer demand for evidence-based parenting programs show low response and attendance rates,³⁷ suggesting these lengthy and often inflexible interventions are not well received.

These issues have particular significance in rural Appalachia, where children and families struggle with a number of health disparities³⁸ and unhealthy behaviors³⁹ associated with poorer mental health.⁴⁰ Regional data show rates of psychosocial concerns presenting in pediatric primary care are higher in Southern Appalachia than rates reported in studies of national samples using the same methods.⁴¹ There are a number of unique challenges for patients seeking mental health services in rural areas.⁴² Polaha et al. demonstrated that, even when these barriers are taken into account, parents who perceive stigma around getting help for their child express less willingness to seek in a traditional community mental health setting.⁴³ In fact, there is evidence that people in rural Appalachia access mental health less than a comparison group outside the region.⁴⁴

Evidence Statement: Identifying psychosocial needs through screening and providing *accessible* interventions is essential to mitigating poor outcomes. Behavioral science offers a range of long-standing, evidence-based screening and treatment strategies that can be deployed in community-based settings where families are likely to seek or accept help. Two of the strongest pathways that have been explored are school and primary care settings. Each of these two

settings has its respective strengths in terms of accessibility, feasibility (for screening and intervention), and cost-effectiveness. A review of the evidence around the merits of each are outside of this review; it is sufficient to point out that both are well-supported. If screening and treatment for psychosocial concerns in children were available in both settings, accessibility would be optimized. An evidence statement focused on each setting in turn follows.

Screening in Primary Care. The benefits of integrating behavioral health into primary care are widely acknowledged.⁴⁵ One recent meta-analysis of 31 randomized controlled trials showed a significant effect for integrated over usual primary care for children and adolescents, especially when the collaborative services focused on a specific, evidence-based treatment.⁴⁶ Integrated primary care models have established screening and treatment pathways for children with psychosocial concerns, and local evidence shows these have high provider adoption and penetration into the at-risk population.

While there are a number of screening tools that can be deployed, the Pediatric Symptom Checklist (PSC) is supported by the American Academy of Pediatrics and reimbursed by third-party payers. The PSC is a frequently used measure and has strong reliability and validity. In local studies, approximately 15% of parents in pediatric clinic waiting rooms rated their child as having clinically significant concerns on the PSC.⁴⁶

School Based Mental Health. A growing body of literature supports the integration of mental health services into the schools.⁴⁷ Like the integrated primary care model, this delivery mechanism relies on an effective screening process that identifies at-risk families and then provides them with accessible treatment.

One universal tool that can be used to implement a screening process in schools is the Behavioral and Emotional Screening System (BESS). The BESS is designed to be completed in less than five minutes per student, with no training required for administrators. The instrument is intended to identify various behavioral and emotional strengths and weaknesses, and identify children as having “normal,” “elevated,” or “extremely elevated” levels of risk. This tool can be utilized as an initial universal assessment to identify students in need of further evaluation.⁶⁴

Using the Youth Risk Behavior Survey (YRBS), created by the Centers for Disease Control and Prevention, can also provide schools with important data about the mental health and prevalence of risk factors in their student population. The CDC provides guidelines for schools on how to administer the survey, analyze the results, and report the findings to community members.⁶⁵ This universal method for screening allows school administrators to identify common risk behaviors among students. However, because the surveys are anonymous students struggling specifically with mental health issues are not be able to be identified for follow-up care. Reducing stigma around mental health must be a primary goal if service delivery is to be effective within the youth population. Currently it is difficult to begin discussions within communities and schools about potential mental health issues children may be experiencing, which creates a barrier to prevention.

The Systematic Screening for Behavioral Disorders (SSBD) is a school-based screening system that collects diagnostic measures to identify children in need of special education services. Information collected from parents/teachers and direct observations is utilized to determine the specific Individualized Education Plan (IEP) for the child.⁶⁶ Adoption of evidence-based practices from Specialized Education Services Inc.(SESI) schools that have shown success would greatly benefit special needs children in Northeast Tennessee and Southwest Virginia. Some practices utilized include:⁶⁷

- Comprehensive support network
- Positive reinforcement
- Reward-based incentives
- Mutual respect
- Strong therapeutic approach

Evidence-based and accessible treatment. Over the past 50 years, the field of behavioral science has developed a strong evidence base for a number of interventions for children with psychosocial concerns, mostly focused on parent-training approaches. In recent decades, the core components of those interventions have been adapted to family-oriented model of care that is brief and intended for deployment in more accessible settings such as primary care and schools. This intervention, the Family Check-Up (FCU), is recognized as an evidence-based prevention program by Blueprints for Healthy Youth Development,⁴⁸ and is one of seven programs designated by the Agency for Children Youth and Family's Home Visitation (HOMVEE) program,⁴⁸ SAMSHA's National Registry of Evidence-Based Programs and Practices (NREPP),⁴⁹ Crime Solutions,⁵⁰ and NIDA Red Book.⁵¹

The FCU is a family-centered, secondary prevention program typically referred to as *parent training*.^{52,53} The FCU, a tailored, adaptive approach to intervention,⁵⁴ has been tested in multiple randomized prevention trials with ethnically diverse families and in diverse service delivery contexts, including public middle school environments⁵⁴⁻⁵⁷; the Special Supplement Nutrition Program for Women, Infants, and Children⁵⁸; and community mental health agencies.⁵⁹ Randomized prevention trials of the FCU in childhood and adolescence consistently indicate that families most in need of family intervention (e.g., single parents, high-conflict homes) have higher rates of engagement.⁶⁰ When families receiving services in community mental health agencies participated in the FCU, they engaged in significantly more treatment sessions than did families receiving treatment as usual.⁵⁹ Further, race/ethnicity and gender have not been related to FCU outcomes and the FCU has been successfully applied to various culturally diverse groups with intervention effects on parenting skills and youth outcomes.⁶¹ In addition to English, FCU services have been delivered in Spanish and all materials have been professionally translated. The NIDA, NIAAA, NICHD, CDC, and IES have provided support for these trials.

Recommendation: Screen all children and their parents regularly for emotional and behavior problems and provide timely, evidence-based, family-centered interventions to promote healthy psychosocial development.

D. Promote family strengths with increased access to in-home services that support child development and parenting

Problem Statement: Family stress, which undermines the ability to provide supportive and stimulating environment for children, can have long-term effects on the health and development of children, youth, and adults.

Evidence Statement: Home visiting programs, which are now supported through both federal and state initiatives, are an important strategy for disseminating education, support, resources, and evidence-based parenting practices to families. A range of home visiting programs have been established with varying evidence, child and family participants, and targeted outcomes. This review of engaged programming and outcomes highlights primary examples.

Early Intervention. Home visiting programs targeting early intervention are available to all families who are high risk or who qualify for these services. Tennessee and Virginia have regional entry points connecting families upon referral from healthcare professionals, or by a direct request by parents. The Tennessee Early Intervention System aims to begin programming with families in the home within 30 days of consent. In the Northeast sector, the percent of families who receive services in this timeframe is 97.66% which is marginally higher than the state average. The percent of families receiving services in the home is 10% lower than the state at 70.93%.⁴⁸ By all outcome measures including positive social-emotional skills and cognitive skill building, the Northeast region is comparable or higher performing than the rest of the state.⁴⁸

The Virginia Department of Education provides the same early intervention services in every sector of the state, coordinated through central entry points. Data for the Southeast region are not available, but trend data for the state suggest improvements in timely delivery of services. In 2013, 98% of families began to receive services in a “timely manner,” which was up from 72% in 2005.⁴⁹ Positive impacts of the program and cognitive, social, and emotional development are comparable to Tennessee’s data. Increased funding for services, referral infrastructure, and measurement can better ensure the population of children with disabilities in the region is being adequately supported. As mentioned in previous sections, transportation services will be essential to the success of any early intervention program.

Pregnancy and Infancy. The Nurse Home Visitor program seeks to improve pregnancy outcomes, child health and development, as well as the economic self-sufficiency of the family. Visiting nurses accomplish this by helping parents develop goal setting skills, plan future pregnancies, obtain additional education, and find jobs. In 2014 this program served 154 low-income, first-time mothers from 28 weeks of pregnancy through two years after giving birth. Funding is provided by the state of Tennessee with an annual cost per child of \$4,168. The program outcomes reveal participants in the Nurse Home Visitor program exceed Tennessee state averages on measures including child abuse and neglect, child

immunizations, infants who get screened for developmental issues, and mothers who do not smoke during pregnancy (Tables 2 and 3).

Table 2. Tennessee Healthy Start program outcomes, 2014.⁶²

Outcome Measure	Healthy Start Participants	TN Population at Large	HP 2020 Target
CHILD OUTCOMES			
Children are free of abuse and neglect	98.4%	99.57%	99.15%
Children are up to date with immunization by 2 nd grade	94.3%	75.4%	89%
Children receive periodic developmental screening	100%	38.3%	Comparable national target not available
MATERNAL OUTCOMES			
Mothers receive early and consistent prenatal care	96.1%	71.1%	77.9%
Mothers delay a subsequent pregnancy for at least 12 months after the birth of the previous child	96.1%	93%	Comparable national target not available

Table 3. Tennessee Nurse Home Visitor Program, 2014.⁶²

Outcome Measure	Healthy Start Participants	TN Population at Large	HP 2020 Target
CHILD OUTCOMES			
Children are free of abuse and neglect	100%	99.57%	99.15%
Children are up to date with immunization by 2 nd grade	95%	75.4%	80%
Children receive periodic developmental screening	100%	38.3%	Comparable national target not available
Infants are born to mothers who did not smoke during pregnancy	93%	83.3%	98.6%

Prevention of Abuse and Neglect. The Child Health and Development (CHAD) program is designed to enhance the physical, social, emotional, and intellectual development of children, to educate parents in positive parenting skills, and to prevent child abuse and neglect. This program is currently offered in 22 counties in Northeast and East Tennessee through local public health departments from birth to 6 years old. Funds to support this program come from the State of Tennessee with a current cost of \$1,023 per family. While 90% of children are “free of child abuse and neglect” compared to 99.57% in the state of Tennessee, 86% of children enrolled in the CHAD program are up to date with their immunizations by age two compared to only 75.4% of children in the state as a whole (Table 4).

Table 4. Tennessee CHAD program outcomes, 2014.⁶²

Outcome Measure	Healthy Start Participants	TN Population at Large	HP 2020 Target
CHILD OUTCOMES			
Children are free of abuse and neglect	90%	99.57%	99.15%
Children are up to date with immunization by 2 nd grade	86%	75.4%	80%

Broad Home Visiting Programming Coordinating Services. In Virginia, federal grants for home visiting programs allowed workers to make 16,542 home visits in 27 of Virginia's 95 counties offering services to 1,245 families.⁶² Federal funding, however, is a limited measure of the total expenditures for serving families in the state. The Virginia Home Visiting Consortium (HVC) utilizes funding from many sources (e.g. Early Intervention, Project LINK, Medicaid, and state funds) to work with programs across the state to ensure quality programming, train staff, leverage resources, and coordinate programs for greatest impact.⁶³ Member organizations offer the a number of models across the state, including CHIP of Virginia, Early Head Start, Healthy Families, Healthy Start/Loving Steps, Nurse Family Partnership, Parents as Teachers, and Resource Mothers. Statewide, the HVC boasts 9,066 families served by 450 full-time home visitors in 110 communities, meeting 7.5% of need through \$34 million public and private investment.⁶³ In Southwest Virginia the HVC partners with 14 agencies providing home visitation services to families in the region. Services include:

- Increasing access to health care for low-income families
- Case management for pregnant, parenting, and at-risk women of childbearing age
- Prenatal education services
- Homemaker services
- Substance abuse treatment services
- Parenting education
- Assistance with child care access
- Service coordination for children with disabilities
- Providing books for children to read
- Child development education
- Connecting families for social outlet
- Transportation services
- Smoking cessation programming
- Encouragement for children to receive immunizations
- Planned pregnancy

Outcomes information is not specifically available for the state of Virginia, but Healthy Families America evaluation results that include more than 20 states and over 12 randomized control trials indicate positive outcomes for families participating in home visits including: reduced child maltreatment, improved child health, improved parent-child interaction, improved school readiness, improved family self-sufficiency, and improved coordination of services and referrals.⁶³

The State of Tennessee Home Visiting report for 2013-2014 reported that evidence-based home visiting programs are currently available in 50 of Tennessee's 95 counties. These programs served 3,700 families in fiscal year 2014.⁶²

Recommendation: All families at risk for poor child outcomes should be offered in-home supports to help them provide an optimal environment for child safety, health, and development

E. Increase access to comprehensive and multi-specialty services for children with chronic diseases

Problem Statement: Children with chronic disease in Northeast Tennessee and Southwest Virginia have limited access to high-quality specialty care. As a result, they suffer worse outcomes that have lifelong significance in their function, quality of life, and life expectancy.

Evidence statement. Serious chronic diseases in children are increasing in prevalence due to improved medical treatment for diseases such as disorders of development, seizures, asthma, type I and II diabetes, cystic fibrosis, cerebral palsy, and mental and behavioral disorders among others. The life expectancy for children with certain serious chronic conditions has increased substantially in the last 40 years. For example, the current life expectancy for children with cystic fibrosis is 50 years of age. For most serious chronic conditions, children need a multi-disciplinary approach that includes specialty pediatricians, allied health, social work, nutritionists, and psychologists. Unfortunately, in Northeast Tennessee and Southwest Virginia there are serious gaps in technical expertise to treat many childhood chronic diseases. For example, the closest specialists or programs to treat cystic fibrosis are at least two hours away. Integrated services for children with cerebral palsy do not exist in the area. Until recently the Tri-Cities area lacked critical specialists such as pediatric endocrinologists, gastroenterologists, and neurologists. Integrated services for children with chronic disease are also very limited. Moreover, many families in Northeast Tennessee and Southwest Virginia are also challenged by food insecurity, poor housing, poverty, and lack of transportation limiting access to treatment services and other health-related social services. While many of these services are available outside the region, the majority of families struggle to access these services due to the above challenges. Many rural areas in the region experience a clustering of risk factors, resulting in gaps in care and high rates of serious preventable morbidity and mortality of children with chronic disease. The lack of care and the increased rates of preventable suffering creates enormous stress for families of children with special healthcare needs.

Evidenced-based approaches to increase access to services for children living with chronic disease exist, including: care coordination, medical home, interdisciplinary teams, and telemedicine, as described in this committee's report and that of the Mental Health and Addictions Steering Committee. These programs can be developed to cut across multiple specialty areas sectors. To implement these approaches will require an investment of resources to hire pediatric specialists and develop coordinated approaches to care for the children of this region. Given the geographic and transportation barriers in the region, outreach and telemedicine approaches should be developed so care for children with serious chronic disease can be delivered as close to home as possible.

Recommendation: Attract additional pediatric specialists and pediatric allied health providers to the region, build interdisciplinary teams, and develop outreach services utilizing telehealth and other technologies, with the end result being a comprehensive system of care for children and youth with chronic disease.

F. Increase access to dental screening and dental preventive care and restorative care

Problem Statement: Poor dental health is the most common chronic condition affecting children in the region. Many rural Appalachian communities lack fluoridation of the tap water due to geographic barriers and the reliance on well water. The lack of fluoridation in drinking water can disproportionately affect children in poor and minority communities who are not as likely to receive preventative interventions, which increases morbidity and cost of dental health care.⁶⁸ Access to dental services is one of the major challenges to the region; not only because of the tremendous need, but also because of an inability to recruit practitioners to the area. Affordable dental care is unavailable for many people across the region, limiting them to the utilization of program like the Remote Area Medical (RAM) Volunteer Corps which holds a handful of events to provide free dental, vision, and health care to communities in Tennessee and Virginia. In 2015, RAM held four events in Appalachia. At each one thousands of people were served, with 80-90% of those seen were for dental concerns.⁶⁹ Unfortunately RAM does not meet the needs of the region with regard to ongoing and non-episodic dental care, but only sees a small portion of the population; often at a point when the only option is tooth extraction.

Evidence Statement: Primary care and school-based dental sealant delivery programs in areas of low socioeconomic status are recommended to mitigate the effects of poor diet and untreated drinking water. Research has shown that these programs can significantly reduce the number of dental caries in children who receive sealants.⁶⁸ In conjunction with providing sealants to children, parents should be educated on how to provide and teach good dental hygiene to their children, using fluoridated toothpaste, and how to avoid sugar and other negatively impactful ingredients in their child's diet.

Recommendation: Increase access to dental varnish, water fluoridation, population-wide dental health education and other preventive dental services for all children in the region.

G. Reduce hunger and food insecurity among expecting mothers and children

Problem Statement: When establishing a good foundation for children, nutrition is key, particularly in the first three years of life. As food insecurity is harmful to individuals of all ages, it is particularly devastating among young children, as it increases their vulnerability and likelihood of long-term consequences. In short, food insecurity threatens the creation of a solid foundation for children's future academic success, and mental and physical health.

Evidence Statement: According to Feeding America's food insecurity data, approximately 13.2% of individuals in Southwest Virginia, and 15.8% of individuals in Northeast Tennessee, are currently food insecure.⁷⁰ Infants and young children living in a food-insecure home have stunted development and are more vulnerable to poor health in the early stages of life.⁷¹ Pregnant women who

are food insecure are more likely to experience birth complications.⁷² Food insecurity has also been shown to elevate the risk for low birth weight in infants.⁷³ In the first two years of life, food insecurity has been linked to learning difficulties and delayed development.⁷⁴ Research has shown that food insecurity creates health problems for children, hindering their ability to fully participate in school and function normally. These studies report that food insecure children are more likely to be hospitalized,⁷⁵ have a high risk for asthma and anemia,⁷⁶ and oral health problems. When looking at behavioral health in school, food insecure children have greater risks for social difficulties such as truancy and tardiness,⁷⁷ anxiety,⁷⁸ and mood swings.⁷⁹

In order to combat food insecurity, Second Harvest Food Bank of Northeast Tennessee has implemented several food assistance programs created specifically for children in the region. The Food For Kids Backpack program provides children in need with an array of healthy snacks and easy-to-prepare meals on weekends, and is currently serving around 5,000 children.⁸⁰ Kids' Cafe provides food to children and youth programs where over half of the participants are under the poverty level, and serves an average of 636 children a month.⁸⁰ Tennessee also offers a Summer Food Service program that utilizes food vendors in the region and volunteers through the Corporation for National Community Service 'Summer VISTA' program to provide children with nutritious foods.⁸⁰ The most successful and cost-effective approaches target children while they are in school, because food can be distributed to a significant amount of children in a short time without traveling from house to house in a given community. Second Harvest Food Bank also operates the Mobile Food Pantry every week, which currently serves about 50 sites within the region and distributed 1.5 million pounds of food to over 55,000 individuals in FY14, the highest distribution of any direct service Food Bank Program.⁸⁰

Feeding America Southwest Virginia is the food assistance program for the 9th congressional district of Virginia. The organization manages the gather and delivery of more than \$31 million worth of food donations in the region through its partnership with 373 feeding programs.⁸¹ Children who participate in feeding programs can show marked improvement in school attendance, test scores, behavior, and health. Food is an essential building block for anyone, especially to a hungry child.

Recommendation: Increase access and participation among children and families in public and private feeding programs to reduce food insecurity.

III. Supported and Empowered Youth

The following objectives were developed to meet the goal of maximizing youth potential and their transition to post high-school education and work.

- A. *Reduce teen pregnancy through increased access to evidenced-based pregnancy prevention education and long-acting reversible contraception (LARC) methods*

Problem Statement: In Tennessee and Virginia, according to anonymous high school surveys (Youth Risk Behavior Survey conducted in all 50 states annually), by high school graduation half of high-schoolers have had sex and 15% have had multiple (> 4) partners since becoming sexually active. The teen birthrates in many Northeast Tennessee and Southwest Virginia counties are 50% to 100% higher than in their respective states or in the nation. Teen pregnancy is associated with multiple untoward outcomes including failing to graduate from high school, increased abortion rates, poverty in adulthood, and repeat pregnancies. Fewer than half of teen mothers graduate from high school and only 2% obtain a college degree by the time they are 30 years of age.

Evidence Statement: Reducing teen pregnancy should be a high priority for future community initiatives because: a) there are evidenced based approaches to successfully prevent teen pregnancies; and b) the lifelong benefits greatly exceed the cost of the programs. As a first step, comprehensive, evidenced-based sexual health education should be made available to all teens. This would result in the reduction of unwanted or unplanned pregnancies and reduce unsafe sexual practices and prevent the spread of sexually-transmitted infections, including HIV. Comprehensive sexual health education curriculum includes elements relating to:⁸²

- Human development
- Relationships
- Decision making
- Abstinence
- Availability of comprehensive contraception options, including LARCs
- Disease prevention

These programs have been shown to significantly reduce the risk of early sexual initiation, having multiple sexual partners, and inconsistent condom and contraceptive use.⁸³

Although almost all sexually active adolescents report having used some method of contraception during their lifetimes, they rarely select the most effective methods. Adolescents most commonly use contraceptive methods with relatively higher failure/misuse rates such as condoms, withdrawal, or oral contraceptive pills. Nonuse, inconsistent use, and use of methods with higher failure/misuse rates in sexually active teens result in the high rate of unintended adolescent pregnancies. Over 80% of adolescent pregnancies are unplanned. The most effective forms of birth control are LARCs, which include the implant Nexplanon and two new intra-uterine devices (Mirena and Skyla), both of which can be used in teens and other women who have never given birth. Both methods may remain in place for at least three years, are highly effective and require no ongoing effort by users. The implant is inserted into the inside of the upper arm in a 15 minute procedure by a clinician who has completed the requisite training. Implants are ideal for adolescents who prefer a method that does not require regularly scheduled adherence and who desire an extended length of protection. Similarly, the IUD methods can be inserted in a brief procedure by providers trained in the

method. Despite past concerns, IUDs are now known to be safe for adolescents who have never given birth. These contraceptive methods have the highest rate of success and satisfaction of all reversible methods with typical and perfect use failure rates of less than 1%--improving the effectiveness of contraception compared to other methods by 20 times.⁸⁴ Community programs to increase access to LARCs substantially reduced pregnancy rates compared to U.S. teens. Under the Affordable Care Act, these methods of contraception are covered under all insurances.⁸⁵

Recommendation: Increase access to evidenced-based pregnancy prevention programs and promote the use of LARCs for teens in Northeast Tennessee and Southwest Virginia

B. Increase the number of high-school graduates pursuing post-secondary education or career training

Problem Statement: Northeast Tennessee and Southwest Virginia are below the national and state averages for engagement by youth in post high-school education or vocational training.

Evidence Statement: Early intervention in high schools to increase likelihood and ability to transition into a college or vocational program begins with identifying students who do not learn at the same pace, or struggle with certain courses, and addressing their needs. Disadvantaged students that live in a low socioeconomic status household may not be given the same opportunities as others. The more frustration and lack of confidence students have in their learning ability, the less likely they are to continue seeking education past a GED. Many students do not realize that a four year university isn't the only option, and that vocational/community colleges are great ways to develop a career. Partnerships with local community colleges and employers can offer students traineeships and job shadowing to give them a perspective of what career they want to pursue.⁸⁵ Tech prep is an example of an intervention that combines two years of secondary education along with two years of post-secondary education that integrates academic, vocational, and technical instruction.⁸⁶

Educational attainment has become more important to our economic success than ever before. Far more jobs are requiring more education and credentialing, and individuals with only a high school diploma are finding it increasingly difficult to enter the workforce. Today the number of jobs that require post-secondary education has doubled over the last 40 years.⁸⁷

Academic achievement by 8th grade is one of the largest predictors of college readiness. Research has shown that the higher the level of academic achievement by 8th grade, the greater impact on college and career readiness.⁸⁸ In order to increase this achievement, interventions that provide summer enrichment programs and college visits among middle and high-school students can help students understand post-secondary pathways.

Recommendation: Increase early-intervention programs using evidence-based models that identify students early and follow them through high school and college, providing a suite of student supports to prepare them for college or work, including tutoring, mentoring, college visits, summer programs, career and technical education, and scholarship funding.

C. Provide services to reduce teen suicide and teen suicide attempts

Problem Statement: In 2013, suicide was the second leading cause of death in people age 12-18.⁸⁹ The Youth Risk Behavior Survey data demonstrate that 8-9% of youth have attempted suicide and double that number have planned a suicide attempt in the past 12 months.

Evidence Statement: Young people's suicides often follow a crisis. For over one in three, the police or medical examiner noted that a crisis such as an argument with a parent or relationship break-up occurred the same day as the suicide. Adolescent boys 15 to 19 years old had a suicide rate that was six times greater than that of their female counterparts, whereas the rate of suicide attempts was twice as high among girls as among boys.⁹⁰ The ratio of attempted suicides to completed suicides among adolescents is estimated to be 50:1 to 100:1. Thirty to forty percent of teens who die by suicide have made a prior attempt. Youth-friendly suicide hotlines have been effective in substantially reducing suicide attempts.

Screening is an important tool needed to identify the many risk factors that may lead a teenager to suicide, such as depression, experiencing bullying, and social isolation.⁹¹ Once identified, the community can work to create environments for at-risk teens that are socially accepting, safe, and inclusive to prevent suicide. Validated screening tools exist that can be used in schools, healthcare provider offices, or emergency rooms.⁹² Columbia Health Screen, and other screening programs, identify suicidal risk factors early in teenagers and can notify parents of the potential risk to help teens access mental health services in their area.⁹³ The program places emphasis on prevention by identifying risk factors as early as possible to keep teenagers safe and out of trouble. A school-based prevention program called "Stop a Suicide Today!" educates individuals to be aware of the behaviors of friends and family members, and to advocate for them to seek help when needed.⁹⁴

Recommendation: Implement universal teen screening for antecedents to suicide attempts and provide community wide, accessible, youth-friendly, and evidence-based suicide prevention and mental health programs.

Measuring Success

The metrics below are expected outcomes from the work described above. There are likely to be other benefits associated with addressing the Healthy Children and Families priorities, but what is included here is what the committee feels are representative of the positive outcomes that are expected.

Focus Area	HCF Specific Priority	Metric	Source
Healthy Start	Increase access to high quality prenatal and postnatal care including new models of supportive prenatal care such as Centering Pregnancy	Reduced infant mortality	Vital records
		Reduced low birthweight rates	Vital records
	Increase delivery of services to prevent alcohol, drug, and tobacco use in women of child-bearing age	Reduced NAS	TN NAS Surveillance
		Increased percentage of new mothers reporting no alcohol, tobacco, or drug use in the last three months of pregnancy*	Pregnancy Risk Assessment Monitoring System (PRAMS)
	Increase support for breastfeeding initiation and continuation	Increased percentage of mothers who report currently breastfeeding or feeding pumped milk to baby	
Ready To Learn	Promote family strengths with increased access to in-home services that support parenting	Increased funding for Head Start programs	Early Childhood Learning and Knowledge Center (ECLKC)
	Actively screen all children and families for psychosocial and parenting needs	Family checkup	Data pending
	Improve educational and social readiness of children under 5 in preparation to enter kindergarten through community-wide measurement and interventions	Increased percentage of prekindergarten children ages 3-5 who participate in home literacy activities with a family member three or more times in the preceding week	National Center for Educational Statistics (NCES)
		Percentage of 3- to 4-year-old children and 5-year-old children in preprimary programs attending full-day programs	National Center for Educational Statistics (NCES)
		VA and TN status of securely linking child-level early care and education (ECE) data across ECE programs – linked across all programs	Early Childhood Data Collective
	Increase access to affordable, high-quality early education for children with special needs (atypically developing children)	Increased funding allocation for children with disabilities with Head Start programs	Early Childhood Learning and Knowledge Center (ECLKC)
	Increase access to comprehensive and multi-specialty services for children with chronic conditions	Lower chronic disease mortality in children and adolescent population	CDC Wonder
	Increase access to dental screening and dental preventive care and restorative care	Lower rate of dental caries in children and adults	State Oral Health Survey (Not Currently Active)

Focus Area	HCF Specific Priority	Metric	Source
	Reduce hunger and food insecurity among expecting mothers and children.	Families can meet their basic needs for food, clothing, shelter, and transportation.	USDA Food Environment Index
Supported and Empowered Youth	Provide services to reduce teen suicide and suicide attempts	Reduced teen suicides completed	CDC Fatal Injury Reports TN Suicide Prevention Network VA Performs
	Reduce teen pregnancy through increased access to evidenced-based pregnancy prevention education and Long Acting Reversible Contraception methods.	Fewer teen pregnancies and births	KidsCount Data Center
	Increase the number of high school graduates pursuing postsecondary education or career training.	Improve post HS outcomes	YRBS; Proposed Quillen College of Medicine Survey of High School Students

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Mental Health and Addictions Steering Committee

Chairs

Dr. Teresa Kidd, President and CEO, Frontier Health

Eric Greene, Senior Vice President of Virginia Services, Frontier
Health

Mental Health and Addictions Steering Committee Members

Last Name	First Name	Organization	Title
Abner	Dr. John Paul	Milligan	Professor of OT & Psychology
Bailey	Marlene	Woodridge Hospital	Director, Behavioral Health Programs
Bangle	Rev. Jim	Retired Lutheran pastor, LCSW, Law Enforcement Chaplain	
Benedetto	Kathy	Frontier Health	SVP, Children & Youth Services
Bowen	Diane	Frontier Health	Director of Compliance and Performance Improvement
Chase	Anna	Mount Rogers CSB	Director of Youth and Family Services
Collins	Margie	City of Bristol, VA Circuit Court	Drug Court Coordinator
Fox	Jeff	Highlands Community Services	Executive Director
Goodkin	Dr. Karl	ETSU	Chair, Dept. of Psychiatry
Greene	Eric	Frontier Health	Senior VP
Hagy	John	Russell County Medical Center	Director of Clearview
Holmes	Rebecca	Highlands Community Services	Clinical Director
Jessee	Dr. Randy	Frontier Health	Senior VP, Specialty Services
Jones	Kristie	Cumberland Mountain CSB	Director of MH Services
Keen	Doug	Wellmont Health System	Program Manager Department of Psychiatry
Ketron	Chris	NE State Community College	Adjunct Faculty
Kidd	Dr. Teresa	Frontier Health	President and CEO
Larsen	Mark	Mount Rogers CSB	Director of Adult Behavioral Health Services
Lindenbusch	Sue	Wellmont Health System	SVP, oncology & behavioral health
Loyd	Dr. Stephen	VA Mountain Home	Associate Chief of Staff
McClaskey	Cynthia	SW VA Mental Health Institute	Director
Melton	Dr. Sarah	Gatton College of Pharmacy at ETSU	Associate Professor of Pharmacy Practice
Melton	Dr. Hughes	Mountain States Health Alliance	Director of GME Program
Mills	Dr. Lori	Milligan College	Professor of Psychology
Moore	Elliott	Mountain States Health Alliance	VP, Government Relations
Moser	Dr. Michele	ETSU	Psychologist
Mullins-Potter	Karrie	Frontier Health	Peer Specialist, VA Operations
O'Dell	Sandy	Planning District One	Executive Director
Pack	Dr. Rob	ETSU	Assoc. Dean Academic Affairs
Page	Joe	Frontier Health	Senior VP, Outpt Services
Plummer	Dr. Robert (Bob)	ETSU	AVP, University Advancement
Rainey	Alice	SAGE	SAGE examines needs and service gaps for seniors
Rice	Dr. Judy	ETSU College of Nursing	Interim Director, Graduate Programs
Richards	Scott	Emory & Henry College, School of Health Sciences	Department Chair
Robshaw	Shannon	Technical Assistance Network for Children's Behavioral Health, University of Maryland	Consultant
Ross	Hon. Todd	Hawkins County, TN	Judge

Last Name	First Name	Organization	Title
Taylor	Ken	Frontier Health	Division Director, VA Child & Family Services
Testerman	Brenda	Frontier Health	Peer Specialist, VA Operations, MH Recovery Coach
Werth	James	Stone Mountain Health Services	Behavioral Health & Wellness Services Director
White	Lindy	Franklin Woods Community Hospital /Woodridge Hospital	CEO

EXECUTIVE SUMMARY

Mental Health and Addictions Steering Committee

The Mental Health and Addictions steering committee was tasked with evaluating the current state of services for adults and children in the region with the goal of reducing the prevalence and consequences of substance abuse and mental health problems in Northeast Tennessee and Southwest Virginia. The committee identified three aspects of an effective mental health and addiction prevention and treatment system of services. These are:

- Early signs of substance abuse and mental health problems identified in the population
- Effective prevention, early intervention, and a full continuum of treatment services available for all
- Integration within the community throughout the early identification, treatment and recovery processes

As is described in earlier sections of this report, Northeast Tennessee and Southwest Virginia are experiencing high rates of substance abuse, especially the abuse of prescription medications. When asked what the health priorities in the region are, community members overwhelmingly identified substance abuse as one of the top issues, with access to intensive and/or specialized treatment services as a main factor. This result, along with the committee's expert assessment of the regional needs, suggests that efforts to improve and expand the delivery of prevention and certain specialized or intensive treatment services for mental health and substance use disorders is a vital component to any plan to improve health in the region.

Recognizing this, the committee worked tirelessly to identify the gaps and to conceptualize how professionals across sectors can coordinate to fill them. Many of the ideas, such as payment reform, included in this report are quite broad and require an investment of resources at the regional, state, and national level to accomplish. The committee felt it was important to discuss these elements so they remain a part of the conversation as essential to making real change in the region.

Other aspects of the report describe the great need for collaboration and innovation in order to reach and serve populations who may be currently unable to receive education or treatment for their mental health or addiction. The partnerships proposed herein are the bedrock upon which an effective system of services is built. Without them, at-risk and vulnerable groups within communities across the region will remain unserved and thus at the mercy of their illness. Care must be coordinated and include support for all health-related social needs (e.g. housing, transportation, food insecurity, etc.) to reduce the prevalence and consequences of substance abuse and mental health problems in Northeast Tennessee and Southwest Virginia.

The report provided herein attempts to summarize the ideas and wealth of information that was generated during the committee meetings. For a more detailed account of the meeting discussions, please refer to Appendix II.

Priority areas

The committee held five meetings between August 20 and November 19, 2015. The goal of the first meeting was to review the charter, break into sub-committees (adult mental health, child and adolescent, addiction and co-occurring disorders), and start the process of identifying gaps in the region with regard to services. Subsequent meetings focused on possibilities for collaboration across sectors, integration of care and proposed opportunities for the new health system to facilitate the committee's objectives. After all meetings were held, a subcommittee was formed to develop an overarching set of priorities from the body of input provided by all members of the committee. The priorities are listed below.

Mental Health and Addictions Priority Areas

- I. **Capacity building:** Identify needs (e.g. specialties, services, beds, etc.) recruit and retain needed professionals in order to build capacity for serving population
- II. **Payment reform:** Increase reimbursement for effective prevention, treatment, and recovery services.
- III. **Active collaboration across sectors in both TN and VA:** Consistency in model delivery as well as coordination of resources between Northeast Tennessee and Southwest Virginia.
 1. Care Coordination: coordination and collaboration for all services needed to address behavioral health issues - "no wrong door"
 - a. Integration of behavioral health and primary care: Intensive care coordination and integration
 - Uses primary care setting to detect behavioral health concerns
 - Integration of services that focus on access improves use of services
 - Reduces stigma by acknowledging the role of behavioral health in physical well-being
 - b. Integration of social welfare and behavioral health services: Integration of social services with behavioral health to build on the delivery of individual health related social needs (e.g. housing, food insecurity, utility needs, interpersonal violence, transportation, etc.).
 2. Data integration and sharing: There needs to be availability of a minimum data set (MDS) regarding availability of services and referrals
 - Interoperability
 - Information on the availability of live data to know what is available in the region
 - Would facilitate consistency across both states in public behavioral health
 - Would improve and accelerate coordination of services and access
- IV. **Community education:** Educational initiatives in the community and clinical settings should be instituted to reduce stigma around mental health and substance use disorder prevention, treatment, and recovery.

Recommended approaches

The committee members identified four main approaches to establish a system of services in the region that is responsive to early signs of substance abuse and mental health problems. This system provides effective prevention, early intervention, and treatment services regardless of gender, race, age, or class and successfully integrates treatment and recovery within the community throughout the process.

- Capacity building
- Payment reform
- Active collaboration across sectors in both TN and VA
- Community education

The committee agrees that these elements must be addressed for region to see a reduction in the prevalence and consequences of substance abuse and mental health problems.

I. Capacity building

The committee members agreed the region's capacity to prevent, identify, and treat mental health and substance use disorders must be developed through a multi-faceted approach that includes: increasing bed capacity for inpatient and residential addiction treatment services; recruitment and retention of specialists; and innovation of service delivery. These efforts, in conjunction with the development of a collaborative network, will effectively increase the capacity of the region's providers to serve the community.

As identified by the committee members through their discussions, the region suffers from a lack of specialized treatment services, especially for children and youth including:

- Crisis stabilization
- Inpatient
- Psychiatry
- Autism spectrum disorders treatment
- Eating disorders treatment

Additionally, there is a general need for more inpatient bed capacity for adults, youth, and children as the region has a great need and limited resources. A review of the inpatient bed map illustrates that there may be a sufficient number of adult inpatient beds; however, two potential difficulties exist with the current beds that on occasion render the number inadequate. The first issue has to do with the given inpatient facility's ability to handle high acuity or co-occurring and/or co-morbid conditions, which is happening much more frequently. The second complicating factor for adult inpatient psychiatric beds is some units are only available for certain populations, such as a geriatric population. Oftentimes individuals needing inpatient services who are high acuity, or who have co-morbid or co-occurring conditions, have to wait until a bed is located (sometimes out of the region) while regional beds sit empty because the facility cannot handle the high acuity individual. Although there is a need for specialized geriatric beds, there are times when these beds sit empty while other non-geriatric adults in need of psychiatric inpatient services either have long waits in emergency rooms to access a bed, or are transported out of region.

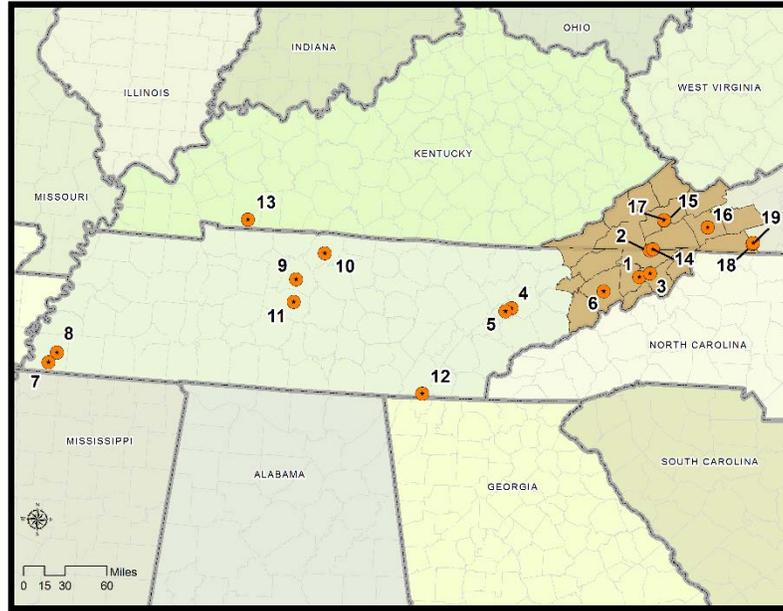
The committee was universally in agreement that an even greater need than inpatient beds for adults in the region is the need for additional and longer term residential treatment and medically monitored residential detoxification services. Although the inpatient psychiatric beds for adults could be restructured to meet the need, there simply is not sufficient availability of residential treatment for substance dependence in our region.

The capacity issue for children and youth is different than for adults. Where we may have an adequate "number" of beds for adults, especially if they were restructured or if the units were able to handle a higher acuity patient, there are truly an insufficient number of beds for children and adolescents in the region. One option to adding inpatient beds for this population would be the development of an adolescent Crisis Stabilization Unit (CSU). Adult CSUs, one of which is in Johnson City and operated by Frontier Health, have been very successful in deferring individuals from inpatient to less costly CSU placement. In some cases, CSUs help individuals shorten their inpatient level of care by being able to step down to the CSU. The addition of a specialized CSU for children and adolescents in the region could help increase the capacity for a higher level of care for youth, and may be more appropriate than adding more inpatient beds. Although most CSU models involve a 3 to 5-day stay, and operate with a full medical model, there is another, less-intensive model operating currently at Highlands Community Services

Board for children and adolescents that offers a day program. This model, in addition to a 24-7 higher intensity CSU, would enhance the continuum of care for children and adolescents in our region.

The addition of residential treatment services for substance dependence, the addition of a children and adolescent 24-7 crisis stabilization unit (CSU), and improved training and recruitment of specialized professionals can effectively increase capacity for higher-acuity adults who need inpatient care using the current bed availability. Figure 1 displays the location and capacity of inpatient treatment facilities in the region. Table 1 lists the residential alcohol and drug residential treatment facilities available.

The recruitment and retention of professionals and specialists (specifically psychiatrists) is a challenge making innovative service delivery methods such as telemedicine attractive as a viable option.



ID Number	Facility Name	City	Potential Adult Psych	Potential Gero Psych	Children Psych	Detox
1	Woodridge	Johnson City	70	14	12	0
2	5 East/Reflections (Bristol Reg. Hospital)	Bristol	0	16	0	0
3	New Leaf (Sycamore Shoals)	Elizabethton	0	12	0	0
4	Peninsula Hospital	Knoxville	120	0	16	0
5	Parkwest Senior Behavioral Health	Knoxville	16	0	0	0
6	Takoma Senior Care	Greeneville	9	0	0	0
7	Lakeside Behavioral Health	Memphis	0	0	55	0
8	St. Francis Hospital	Memphis	0	0	34	0
9	Vanderbilt University	Nashville	0	0	26	0
10	Skyline Medical Center	Nashville	0	0	21	0
11	Rolling Hills	Franklin	0	0	20	0
12	Parkridge Valley	Chattanooga	0	0	108	0
13	Cumberland Hall	Hopkinsville	0	0	34	0
14	Ridgeview Pavilion	Bristol	21	0	0	0
15	Clearview Center	Lebanon	20	0	0	0
16	Southwest VA Mental Health Institute	Marion	138	41	0	0
17	The Laurels	Lebanon	6	0	0	10
18	The Life Center of Galax	Galax	0	0	0	60
19	Twin County Regional Behavior Health	Galax	10	0	0	0

Figure 1. In-patient Mental Health and Addictions Facilities in the Region, with Bed Type and Capacity

Table 1. Other residential beds in the region, 2016

Type	Name	Location	Treatment Population	Bed Capacity		
				Medically Monitored Detox	Co-occurring Treatment	Total
Crisis Stabilization Unit	Frontier Health	Johnson City	Adult	-	-	15
Residential A&D	Magnolia Ridge	Johnson City	Adult	8	11	19
Residential A&D	Willow Ridge	Johnson City	Women	-	12	12
Residential A&D	Residential Alcohol and Drug Comprehensive Community Services (CCS)	Kingsport	Adult	-	43	55
			Adolescent	-	12	
Crisis Stabilization Unit	Cornerstone	Wytheville	Adult	-	-	6
Crisis Stabilization Unit	New Horizons	Blacksburg	Adult	-	-	6

Telemedicine

Telemedicine is the exchange of medical information via electronic communication such as two-way video, email, smartphones, and other forms of telecommunications software. Telemedicine may help providers overcome barriers associated with treatment delivery in rural areas where there typically is a dearth of specialists and mental health professionals to support the community. There are several case studies that illustrate the potential for implementing telehealth practices for psychiatry in various populations. The use of technology to educate providers and render direct services is a promising approach to expand access to behavioral health services in rural communities.

Studies have shown telemedicine is effective specifically for treating patients who experience social anxiety, agoraphobia, claustrophobia, post-traumatic stress disorder, obsessive compulsive disorder, and substance

abuse disorders.¹ In a recent series of case studies, investigators learned that children with social anxiety or certain forms of autism may experience better outcomes through videoconferencing compared to face-to-face treatment due to the nature of their mental health disorder.² In adult populations, research has shown cognitive behavioral therapy received via telemedicine has been effective at reducing the severity of mental health problems, and reduces the number of unnecessary emergency department visits and hospitalizations for mental health related issues.³

Telemedicine may also be applicable in rural populations where patients experience a dearth of providers, (particularly medical and behavioral specialists) and other barriers to access, such as lack of transportation and financial resources. In rural settings the mental health needs of patients typically fall on primary care providers who may not have specialized mental health and substance use disorders training.⁴ In addition, providers also have to battle against stigma associated with

mental illness and substance use disorder. Unfortunately this cluster of factors contributes to patients often not seeking help until their mental illness is advanced.³

Telehealth can help to remove some of these barriers both for patients and providers. In the Telepsychiatry Consultation Model for instance, a primary care provider refers a patient to a psychiatrist who conducts an evaluation via video conferencing. Through this model, primary care providers can be advised on course of treatment for their patient that may include medication and/or other psychotherapeutic approaches. This model has been particularly effective in rural populations where primary care providers have established relationships with their patients.⁴

It is important to note that the use of telemedicine is relatively new and has generally outpaced thorough and large-scale scientific research.¹ Other barriers to setting up telemedicine programs include: a lack of understanding among physicians about the value and operational implementation of telemedicine; poor advertising of new services; and lack of IT support.⁴ Patients also often have concerns related to confidentiality of information when transmitted electronically, so all telemedicine programs must be in strict compliance with the Health Insurance Portability and Accountability Act (HIPAA).¹ Another substantial barrier relates to reimbursement for telemedical services. It is essential to address insurer reimbursement before program implementation so patients will be able to access necessary services.

There are several case studies that illustrate the effective implementation of telemedicine practices to enhance positive health outcomes for patients. In 2008, a coalition was formed between the University of Alabama School of Medicine and department of Psychiatry and Behavioral Neurobiology, along with regional non-profit mental health prevention and treatment organizations, the Alabama Department of Mental Health, and the Alabama chapter of the National Alliance on Mental Illness (NAMI). The goal of this collaboration was to reduce stigma and support the health of people living with mental illness in rural Alabama. Psychiatrists were solicited from the school of medicine for the provision of telepsychiatry services to patients within the partner non-profit mental health treatment facility.

This effort focused on children, as there was a lack of services provided in the area specifically for youth. The “setup cost” for this program was approximately \$2,000 for equipment plus \$350 per month for operation, plus psychiatrist and physician salary costs. The cost was the greatest challenge to this project since the reimbursements for physicians and psychiatrists remained the same as face-to-face consultations, and there was no additional funding for the setup fees. Steps identified by the project to improve their model are more effective and rigorous data collection, and an evaluation of specific models aimed at generating specific outcomes.³

Project ECHO (Extension for Community Healthcare Outcomes) was developed by Dr. Sanjeev Arora in Albuquerque as a method for connecting healthcare specialists with providers in remote areas to bring the best care to patients with chronic conditions. Dr. Arora was driven to develop Project ECHO in response to thousands of New Mexicans experiencing complications from Hepatitis C who lived in remote locations and did not have access to specialty care.⁵

The model encourages partnership between primary care physicians and specialists who are available to support the primary care physician many times during the patient’s course of treatment. In addition to Hepatitis C, physicians working with Project ECHO also treat complicated conditions such as asthma, diabetes, HIV/AIDS, pediatric obesity, chronic pain, substance use disorders, cardiovascular conditions, mental illness, and rheumatoid arthritis.⁶ For primary care physicians who are treating patients with mental illness, an integrated addictions and psychiatry (IAP) clinic is available on a weekly basis that provides feedback from mental health specialists about specific cases and gives them access to presentations related to mental illness.⁷

Project ECHO also benefits patient by helping healthcare providers provide a treatment plan based on the most current research available. In rural communities where health care professionals are often isolated from their colleagues, Project ECHO connects care providers through a professional network that enables them to use innovative treatments faster. Project ECHO not only benefits patients, but also there is evidence to suggest that the program benefits the practitioners. In rural areas where healthcare providers are often isolated and do not have ready access to professional development opportunities, Project ECHO connects them to other practitioners and helps them to develop their skills. This could help with retention of healthcare providers in rural communities that often experience high turnover rates of medical professionals.⁶

While the application of Project ECHO to behavioral health is currently limited, the model allows for the expansion of services to include the coordination of specialists with rural providers for the expansion of services within their patient populations

School-based services

Access to mental health services for children can also be increased by making them available where children spend most of their day – in school. A combination of funding for prevention and early intervention, along with treatment, is most effective in balancing the needs of the school system and serving children who may not make it in to a treatment center.

Some school-based service delivery models that have been implemented effectively in the Northeast region of TN include:

The **School Based Liaison for At-Risk Youth** program (SBL-ARY) is a grant program jointly funded through both TN State Department of Mental Health and Substance Abuse Services and the TN State Department of Education. The main purpose is to provide face-to-face consultation to classroom teachers to enhance the learning environment for students who are at-risk or already facing the challenges of substance abuse, learning disabilities, behavior difficulties, and serious emotional disturbance. The SBL-ARY provides liaison services between families and the school to increase communication and collaboration necessary for at-risk students. This program is currently available in three counties in the region and could be replicated with additional funding.

Project BASIC (Better Attitudes and Skills In Children) is a school-based mental health early intervention and prevention program that seeks to equip students with life's basics – a positive self-concept, a healthy self-esteem, and social skills. While Project BASIC targets elementary students, it also benefits school personnel and parents. Child Development Specialists (CDS) work within each school to help teachers, administrators, and parents develop an environment that fosters a positive self-concept, and recognizes students in need of early mental health intervention. The goal is to enhance awareness of mental health issues and support school personnel to meet the mental health needs of the children by conducting appropriate presentations in every K-3 classroom on self-esteem, personal safety, and self-care. Presentations may include issues such as coping with divorce or with a death in the family, or building coping skills following a local disaster, which are tailored to the community. The Current Project BASIC sites are funded through federal block grant funding through TDMHSAS.

The Helping Everyone Reach Optimum Excellence and Success (HEROES) project in Johnson City Schools is a school-based mental health service delivery model that was sustained from a federal *Safe Schools/Healthy Students* grant through blended funding streams. Child

development staff, case managers, and therapists are placed in all schools with to provide prevention and early intervention described in the programs above, along with the credentialed staff who can provide direct service delivery on-site within the school when needed. This program provides significant parent intervention and serves as a liaison to child psychiatry services within the traditional clinic model. This program has demonstrated that early intervention and access to care contributes to improved achievement scores. This service could be replicated in other systems with additional resources.

In Virginia's system, Medicaid funds school-based mental health treatment services to school-age children who meet the criteria for serious emotional disturbance (SED) or at-risk of SED (At-Risk). Therapeutic Day Treatment (TDT) is a service that may be provided in either a separate specialized classroom model (i.e., "a carve-out" model) or an integrated classroom model, which allows the child to remain in the normal educational milieu with treatment staff present in the classroom to help. The most frequent iteration of TDT is the integrated classroom model which places a qualified mental health professional (QMHP) with the child throughout the school day. Providers of this service operate from a distinct treatment plan that functions in conjunction with mental health case management and other services. To receive TDT, children must be screened into the program via a clinical assessment from the case management provider which determines the medical necessity for TDT, based in part on the lack of success in less-intensive treatment modalities. Although this has been viewed by as a successful model, it is a service which is only available for Medicaid recipients or through private pay arrangement.

Regardless of which school based model of intervention is used, one of the elements that is critical in rendering school based services is to include parental involvement. Children and adolescents need their caretakers to be involved with them in therapy services. Although school based services can be extremely effective, adding a component of clinic-based services to include the parent(s)/ caregivers, or in-home intervention can strengthen the impact of school-based interventions.

II. Payment reform

Payment reform was at the forefront of the discussions about improving access and delivery of effective mental health and substance abuse services across the region. The scope of payment reform as discussed in the committee included parity and fee-for-service versus pay-for-performance management models.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to make the financial requirements and treatment limitations for mental health and substance use disorder benefits comparable to those associated with medical and surgical benefits. The law applies to private and public sector employers with 50 or more employees, making mental health and addiction services more accessible to millions of Americans.⁸ This effort was further advanced with the passing of the Patient Protection and Affordable Care Act in 2010, which required most individual and small business plans along with the Medicaid Alternative Benefit Plans to offer coverage for mental health and substance use disorders. In addition to treatment services, plans are required to cover some prevention services including depression screening for adults and behavioral assessments for children.⁹

Insurance company compliance with the parity law, however, is not yet widespread, making it difficult for consumers to find a plan to cover their mental health and addiction treatment needs.

In addition, although mental health and addiction treatment may be covered in some plans, the reimbursement rates or provider eligibility requirements often act as barriers to the ability of many providers to render the services in a cost-effective manner.

Currently, most behavioral health services are reimbursed within a fee-for-service arena, with prices negotiated or set by a variety of managed care organizations. Often the rates themselves pale in comparison to rates established for primary care, or carry with them high co-pays (behavioral health is viewed as “a specialty service,” which carries higher co-pays in many plans), which also may be barriers to treatment.

Even when the fee-for-service reimbursement is sufficient to cover the cost of rendering services, fee-for-service models are quantity-based rather than outcomes focused. Fee-for-service arrangements fail to reward providers who strive for more integrated, coordinated care or those who provide excellent primary or secondary prevention. As can be seen in other parts of this report, the committee identified effective prevention, early intervention, and coordinated, integrated service delivery within the community throughout the treatment and recovery process as key elements to develop an effective system of behavioral health care in our community. And these types of services and collaborations are not recognized or reimbursed in a traditional fee for service arrangement. Therefore, a critical element to improve the mental health and addiction delivery service will be pay-for-performance arrangements that are outcome based, rather than driven by quantity of service, and that allow for flexibility and creativity to improve health outcomes for an at-risk population.

Transitioning to outcome-based payment is a national trend that encourages innovative and flexible service delivery promoting prevention, coordination of care, and effective treatment of chronic conditions, with the goal of improving the healthcare outcomes of those we serve. There are a handful of payment programs nationwide that currently offer incentives for meeting performance-based targets. These range from a few hundred dollars per provider to several thousand dollars for provider groups, and recognition of excellence.

Many barriers exist that currently prevent widespread application of performance-based payment. These include:¹⁰

- Lack of consensus on behavioral health quality improvement strategies
- Public-sector payment programs that are non-responsive to market pressure for quality improvement
- Cash payers for many types of care limit evaluation of quality due to lack of market pressures
- Many types of licensed providers make it difficult find to consensus on performance measures
- Relatively few established behavioral health databases making quality measurement difficult
- Concerns over the applicability and validity of performance measures
- Burdensome data collection methodology

In general, behavioral health performance measurement, reporting, and feedback mechanisms are much less developed compared to physical healthcare. Focused efforts must be made to facilitate the uptake of this payment model by payers and providers if it is to gain traction.

Establishing a regional consortium of behavioral health providers, community support partners, and civic leaders will improve the delivery of services and lead to consensus on quality measurement that can be communicated to health plan providers.

As the number one cause of disability and mortality among women and second among men, mental and substance use disorders are considered a priority health issue nationally. The prevalence of behavioral health disorders in Northeast Tennessee and Southwest Virginia is higher than the national average, making the need to attend to these conditions of utmost importance to improving the health of the region. Payment reform that brings high-quality behavioral health services to at-risk populations will be a significant step forward for the regional community.

III. Active collaboration across sectors in both TN and VA

The goal of this effort is to bring about consistency in model delivery and coordination of resources between Northeast Tennessee and Southwest Virginia. Committee members cited the great need for coordination across states so that beds can be utilized that might otherwise sit empty despite the regional need for inpatient capacity. In addition, developing consensus regarding modality of treatment across provider organizations, which benefits the patient population by facilitating continuity of care, is achieved only through coordination across the region.

Care coordination / Integrated care

The committee recognizes the need for coordination and collaboration among all services available to address behavioral health issues in the region. Integrated care benefits patients and improves outcomes by providing treatment for physical and behavioral issues in tandem. This approach has a synergistic effect that can prevent the development and exacerbation of future health conditions, thus lowering healthcare cost and improving quality of life for patients. Integrated care involves an inter-professional team of providers (e.g. physicians, case managers, mental health specialists, etc.) working with a patient to achieve optimal health.¹¹

Coordinated care approaches prevent the “silo effect,” in which patients communicate with multiple health professionals who rarely communicate with each other, thus fragmenting care and making it less effective, and potentially hazardous, to the patient’s health. This approach also reduces stigma regarding mental health disorders by encouraging professional collaboration and communication between medical and behavioral health providers.¹²

There are several organizations that have established guidelines for best practices regarding collaborative care. It is essential for any collaborative care program to adopt a “no wrong door” policy, meaning no matter how a patient enters the healthcare system, all of their physical and mental health needs should be met within that system. Another broad goal of the collaborative care approach relates to a patient-centered care model that is shared among all providers. Rather than asking the patient to seek services outside of the healthcare system, the onus is on the practitioners to collaborate and communicate with each other to provide optimal treatment for a patient’s physical and mental health needs.¹³ Several promising approaches used by state Medicaid programs, health insurance plans, and providers are outlined in the five stages of the integration continuum below.

Universal screenings

Patients should be screened for mental health and substance use disorders when they receive health care. There are several screeners available for use in primary care settings including the patient health questionnaire (PHQ-9) for depression (widely used), the mood disorders questionnaire (MDQ), the suicide behavior questionnaire (SBQ-R), the generalized anxiety disorders questionnaire (GAD-7), the life event checklist (LEC) which screens for trauma, and the Screening, Brief Intervention, Referral to Treatment (SBIRT) tool which is useful to identify substance use issues. These and other screening tools can be offered in a wide variety of settings including primary care centers, trauma centers, emergency rooms, and community settings.

Navigators	Navigators in a healthcare system can assist individuals seeking services for behavioral or mental health conditions with a wide range of tasks. Depending on their training, they can help the patient make appointments and advocate for certain treatment plans, social services, or medical procedures. Navigators can be nurses, mental health case managers, therapists, or trained “peer specialists” who may have experience in the behavioral health system.
Co-location	This concept relates to offering both primary, specialty, and mental health services in the same location for patients. This is particularly important for patients who may have mobility issues due to mental health status, socioeconomic status, or age.
Health homes	Health homes are a sophisticated approach to collaborative care and have been adopted by Medicaid in 19 states and the District of Columbia. A Behavioral Health Home is a model of service delivery for individuals who have a serious mental illness or emotional disturbance. It promotes a cost-effective way to facilitate access to an array of behavioral health, medical care, and community-based social services and supports. The purpose of a behavioral health home is to help individuals with chronic conditions access treatment, foster joint decision making across behavioral and medical health care providers, and instill awareness of the interaction of behavioral and physical health needs in a population with a chronic condition, to include quality and cost impact.
System-level integration	This model illustrates the highest level of integrated care. Physicians, mental health providers, and social workers have an established network of communication and information sharing. No matter which person or organization provides the first point of contact for a patient, they immediately have access to all needed services.

System-level Integration approach can sometimes utilize the expertise of behavioral health consultants (BHC) to work alongside primary care physicians. The primary care provider acts as the team leader and can screen patients for mental health issues, conduct a medical evaluation, prescribe, and monitor patients. The BHC’s role is to provide prevention education to patients on a wide range of topics (e.g. self-care, hygiene, stress reduction, etc.), help the patient learn self-management skills, and help the patient set goals or overcome personal obstacles. In order to be successful, BHCs must possess knowledge of evidence-based treatments, have well-developed communication skills, a working knowledge of pharmacology, and a basic understanding of medicine.

For health systems looking to adopt collaborative care models, there are initial steps they can take to make this a reality. First, behavioral health screening must be adopted into all primary care practice (e.g. PHQ-9 and the SBIRT). Second, health systems should use evidence-based and/or best practice methods for care management, supervision, support, and evaluation that are shared by all practitioners throughout the healthcare system. Finally, health administrators

should work to improve and refine the skills of all practitioners within the system to make sure they are able to screen and treat patients for a wide variety of health issues.¹²

Integrated care models have been well-researched and show promising results for affecting positive patient outcomes. A 2012 Cochrane Review found that collaborative approaches are better than routine care for improving symptoms of depression and anxiety.¹¹ The review also found that patients who have access to collaborative care are more likely to take their medication consistently and report higher overall satisfaction with their treatment.¹¹

In addition to establishing a model of integrated care delivery, the committee recommends coordinated efforts be made to build a system of care that is capable of prevention and early intervention with treatment and recovery services integrated in the community. This requires engaging with local government, hospitals, physicians, social service providers, public schools, colleges and universities, libraries, law enforcement, community organizations, and faith-based organizations to build a network that is person-centered, responsive, and effective from prevention to recovery.¹⁴

Several communities across the country have built similar networks, either in response to specific health concerns or changing health laws. Structures supporting these networks vary and include centralized non-profit organizations, those led by a single bridge organization, and decentralized coalitions of providers.¹⁴ The recommended structure for a network to serve the 21-county region of Northeast Tennessee and Southwest Virginia is not yet clear and would be part of the initial strategic planning process.

The mission of the proposed collaborative must be clear and concise. Because rural health is of great concern in the region, the network may choose to focus its mission of developing partnerships for the effective delivery of prevention, early intervention, treatment, and recovery services in the rural communities of Southern Appalachia. The mission should be responsive to the needs of the target community and framed to attract and include needed agencies and providers to the organization.

Deliberate efforts should be made to establish a supportive, egalitarian environment for providers to encourage collaborative rather than competitive relationships between them. The goal of the network is to create synergies that are greater than the sum of their parts by bringing together capable and complementary agencies. Outputs from a successful collaboration include quality improvement, support for evidence-based and/or best practice programming, increased community awareness, increased prevention efforts, greater continuity of care, and community-based recovery.

Community engagement is the bedrock for a provider network in the region whose mission it is to decrease the prevalence of mental health and substance abuse disorders. The stigma associated with these disorders is prohibitive to the provision of effective prevention and treatment. The community must play an active role within the network so that members can be responsive to changing needs within the community, as well as gain access to community resources needed to ensure successful recovery.

Data integration and sharing

One of the significant limitations to the provision of consistent, efficient, and effective mental health and substance abuse treatment services is the difficulty to ascertain what is available and for whom. Northeast Tennessee and Southwest Virginia covers a large area, and coordination

of services is complicated by state-line issues and the mountainous terrain. Related jurisdictional issues preclude people from receiving services they need, even if providers are available mere miles away. In addition, the lack of a centralized resource documenting services means each organization must develop its own network for referrals and call each place every time a need arises.

An interactive, searchable database that is updated in real time would help agencies and individuals know what services are available or what the wait time might be for the receipt of services. Such a database would need to be developed using an interoperable system that would interface across organizations, or at least be easy enough to learn that staff across agencies would be able to monitor and update it without significant additional training.

Currently one of the significant complications for the receipt of services is hard-and-fast service line demarcations. Some people who live near a state border may not be able to access services at a facility near them (but across the state line) because of insurance-company imposed limits. Therefore, instead of travelling only a few miles to receive care, they may have to drive many hours the opposite direction. Similarly, boundaries between public service agencies (e.g., based on county lines) mean that neighbors may have access to widely different types of services. Elimination of these artificial boundaries, or the development of additional resources so that all citizens in all counties of both states have equal access to the same services, would be crucial to the success of any newly formed system; otherwise, knowing that services are available elsewhere but are only available to residents of that locale is more frustrating than helpful.

IV. Community education

Educational initiatives in the community and clinical settings should be instituted to reduce stigma around mental health and substance use disorder prevention, treatment, and recovery. As described in the previous section, the community's role to develop an effective system of care is vital and must be a priority.

Social and structural (i.e. laws and institutional procedures) stigma has a significant impact on the likelihood of individuals with mental health and substance abuse disorders accessing available services. In 2012, respondents to the Behavioral Risk Factor Surveillance System (BRFSS) were asked to indicate their level of agreement with the following statements: "Treatment can help people with mental illness lead normal lives" and "People are generally caring and sympathetic to people with mental illness."¹⁵ In Tennessee, 22% of adults with serious psychological distress strongly disagreed with the statement that people are caring and sympathetic to people with mental illness. That number dropped to 19% in Virginia. These results prompted the CDC to develop general guidelines for engaging community stakeholders and policymakers in reducing stigma associated with mental illness. These guidelines include:¹⁵

- Continued monitoring of mental health status within communities
- Implement evidence-based and culturally competent programs across subgroups within the community
- Encourage local media to incorporate positive messages related to mental health
- Avoid labeling someone as their illness (e.g. rather than saying, "she's bipolar", say, "she has a bipolar disorder")

- Support people in the community with mental illness by showing compassion and increasing available resources.

The general public's view about mental illness and substance use disorders can be modified through basic educational efforts aimed at dispelling misconceptions and stereotypes. However, presentations and interaction by and with those who have been battling these disorders and are successful in their recovery efforts are an even more successful means of dispelling stigma. Programs such as "In Our Own Voice" is one program where individuals who have a mental illness and/or substance use disorder tell their own story of recovery. .These types of initiatives have been used to demonstrate how recovery is possible with treatment and support. Being able to interact directly with individuals recovering from mental illness and addiction has been shown to be the most impactful way of dispelling myths and stigma.¹⁶

Another important way to decrease the stigma associated with mental illness and addiction is to encourage local and national law makers to prioritize funding for prevention and treatment services. Funding cuts and even stagnant funding year after year for prevention and intervention subtly promotes mental illness and addiction services as less important than other expenditures, even though the mental health well-being of any region plays an extremely important role in our overall health, education, and employment success. According to the National Institutes of Health, for every dollar spent on mental health, substance use disorders, or co-occurring treatment, seven dollars is saved in community costs through decreased hospitalization, decreased unemployment and training costs, decreased incarceration, and most importantly, decreased deaths.¹⁷

Measuring success

The metrics below are expected outcomes from the work described above. There are likely to be other benefits associated with addressing the Mental Health and Addictions steering committee's priorities, but what is included here is what the committee feels are representative of the positive outcomes that are expected.

Metric	Data Source
Overdose incidence and deaths decline	County Health Rankings
Fewer overdose-related ED visits	Hospital Admissions Data
Fewer drug-related hospitalizations	Hospital Admissions Data
Fewer alcohol-related MVA	Tennessee Department of Safety and Homeland Security Virginia Department of Motor Vehicles
Fewer DUI Incidences	TN-MADD VA-MADD, VDMV CDC
Less HIV and HCV associated with Injection Drug Use	Tennessee Department of Health Virginia Department of Health County Health Rankings AIDSVU (CDC)
Lower foster care need	KidsCount (Department of Child Services) KidsCount (Virginia Department of Social Services)
Less child abuse and neglect	KidsCount:(Department of Children's Services) KidsCount (Virginia Department of Social Services)
Fewer prison/jails stays	Tennessee Department of Corrections Virginia Department of Corrections
Lower drug initiation rates	YRBS
Increased employment	County Health Rankings
Increased stimulation of partnerships across regions/sectors	Pending/Unknown
Increased funding cross-sector collaborations	Pending/Unknown
Reduced rates of NAS	Mountain States/Wellmont inpatient hospitalization data Tennessee Department of Health Virginia Department of Health

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Population Health and Healthy Communities Steering Committee

Chairs

Dr. Randy Wykoff, Dean of Public Health, East Tennessee State University

Lori Hamilton, Health Educator, K-VA-T Food City

Population Health and Healthy Communities Steering Committee

Last Name	First Name	Organization	Title
Belcher	Phil	Eastman Chemical Company	Health and Welfare Manager
Bishop	Marilyn	Mountain States Medical Group	Medical Director Occupational Medicine
Blackwelder	Reid	American Academy of Family Physicians	
Blevins	Shannon	UVA Wise	Director of Economic Development
Brillhart	Catherine	City of Bristol	Councilwoman
Brock	Jenny	City of Johnson City	Commissioner
Buck	Linda	Rural Health Consortium	Director
Cantrell	Sue	SWVA Health Authority	LENOWISCO Health Director and Vice Chairman
Cook	Heather	Healthy Kingsport	Director
Counts	Melody	Cumberland Plateau Health District	District Health Director
Domst	Ronald	Johnston Memorial Hospital	Retired, Volunteer
Eastridge	Dr. Wesley	Mountain Region Family Medicine	Physician
English	Rebekah	NE TN Regional Health Department	Regional Director
Everhart	Aubrey	Appalachian Mountain Project Access	Executive Director
Farmer	Barbara	Pleasant View UMC; Wesley Clinic	Associate Pastor; Volunteer
Franko	Dr. John	ETSU	Family Medicine
Gail	Dick	AEP	Retired plant manager
Glass	Charlie	Greater Kingsport Family YMCA	Executive Director/CEO
Hamilton	Lori	K-VA-T Food City	Health Educator
Hammonds	Kristie	Frontier Health	SVP, Operations
Harris	Matthew	Mountain States Rehabilitation – JMH	Physical Therapist, Athletic Trainer
Johnson	Stan	Great Body Company	Owner
Kent	Martin	United Company	President
Mayes	Gary	Sullivan County Health Department	Regional Director
Michael	Dr. Gary	Clinch River Health Services, Inc	Family Practice Physician
Morgan	Ed	City of Abingdon	Mayor
Moulton	Dr. David	State of Franklin Healthcare Assoc.	
Nehring	Dr. Wendy	ETSU	College of Nursing
Perkins	James	Wellmont Health System	HVMC/BRMC Diabetes Treatment Center
Purdue	Malcolm	Stone Mt Health Services (FQHC)	Executive Director
Seligman	Dr. Morris	MSHA	EVP, CMO
Sensibaugh	David	Integrated Solutions Health Network	VP, integrated health management
Snodgrass	Dr. Jeff	Milligan College	Chair, Department of Occupational Therapy
Wiley	Mary	Wellmont Hancock County Hospital	RN
Wykoff	Dr. Randy	ETSU College of Public Health	Dean

EXECUTIVE SUMMARY

Population Health and Healthy Communities Steering Committee

The overarching goal of the Population Health and Healthy Communities steering committee was to identify a small number of high impact interventions that the merged system, its partners, and the region could pursue to most effectively improve the health status of people living across the region. The goal of these high impact interventions is to reduce preventable disease prevalence, create a culture of health, and ultimately break the cycle of inter-generational poor health. Meeting these objectives requires a long-term vision and rigorous planning to accomplish, but most importantly to be successful, champions from multiple sectors with a stake in the health of every community in the region must be engaged in the process.

While “population health” can have many definitions, the committee sought to identify any factor or behavior that was impacting the overall health status of the people of the region.

Historically, the 200 or so counties of central Appalachia, including the counties of Northeast Tennessee and Southwest Virginia, have been burdened with some of the highest chronic disease rates in the nation, most of which can be attributed to high prevalence of behaviors such as smoking, physical inactivity, poor nutrition, alcohol and drug abuse, and other behaviors. To impact the inter-generational health of the region, it is important to address these behaviors as they already exist in the region, and also to identify those underlying factors which predict these behaviors in future generations. Successful change in the region’s communities, especially the rural communities, requires working closely with local leaders and stakeholders from the beginning. Not only do these individuals provide access to community support personnel that can inform and deliver prevention programming, but they also bring the deep understanding of each unique community that is necessary for meaningful community engagement and ownership.

Developing a culture of health in the region will require dedicated leadership both within the health system and its partner agencies, and the cooperation and collaboration of a wide-range of regional partners. Establishing cross-sector buy-in allows for the coordination of efforts, the joint identification of priorities, the sharing of resources, the coordination of service delivery, and the mapping of services onto the communities that need them. What is presented below is an outline of the regional population health priorities as they were identified through a series of committee meetings. These priorities have been cross-walked with potential health metrics and their sources. It is important to point out that this outline is not a summary of every program that is needed in the region, nor a comprehensive summary of every intervention that might be beneficial. It is, rather, the work group’s best effort to identify the “high impact interventions” that could have the greatest impact on improving health in the region.

Priority areas

The committee held five meetings between August 24, 2015 and January 18, 2016. The goal of the first meeting was to identify a small set of priorities for the group to focus on when developing recommendations for improving health in the region. Before the meeting, a short survey was administered via email asking for committee members to provide input on the following items:

- From your perspective, what are the most important health challenges in the region that could be addressed by one or more coordinated community-based actions?
- If you could implement ONLY one program to improve health in the region, what would it be?
- What steps should be taken to increase community awareness of our regional health challenges?
- What steps should be taken to encourage and support individuals and families in our region to make better behavioral choices?
- How could we most effectively involve businesses, churches, and schools in promoting health in our region?

Responses to these questions (Appendix II) were then used as a basis for the priority setting discussion at the meeting. The result of the discussion was a set of five priorities for the region:

- Tobacco use and pulmonary health
- Physical activity and nutrition
- Healthy aging
- Behavioral health
- Children's health

It was decided that behavioral health and children's health should be the purview of the Mental Health and Addictions steering committee and Healthy Children and Families steering committee, respectively, so would not be part of the Population Health and Healthy Communities work. Over the next four meetings, support staff presented regional data along with best practices and evidence-based approaches to addressing the three health priorities (tobacco use and pulmonary health, physical activity and nutrition, and healthy aging) for the committee's consideration. The result of these meetings was a set of items, or focus areas, under each priority. These are described below.

Tobacco use and pulmonary health

Based on consideration of national, regional, and local data, the committee felt the following focus areas would most appropriately address tobacco use and pulmonary health in Northeast Tennessee and Southwest Virginia:

- Adolescent smoking prevention
- Pregnancy smoking cessation
- Adult smoking cessation

Physical activity and nutrition

Based on consideration of national, regional, and local data, the committee felt the following focus areas would most appropriately address physical activity and nutrition in Northeast Tennessee and Southwest Virginia:

- School-based physical activity policy and programming
- Worksite-based educational and support programs
- Comprehensive community-based programming

Healthy aging

The committee identified five focus areas to ensure the regional community has access to resources that make it possible for the aging population to maintain health for as long as possible. Those resources include health education, health service navigation, case management, and coordinated care.

- Community support systems
- Coordinated care/case management
- End of life support programs
- Chronic disease self-management programs
- Patient-centered medical homes

Recommended approaches

Through careful review of the program evaluation literature, research staff were able to identify approaches that have either been shown to improve outcomes in the three priority areas or represent current best practices. These approaches were presented to the committee for review and discussion. The resulting set of programs and solutions presented below constitute the recommended strategies for meeting the priorities of the committee.

Through the process of identifying evidence-based approaches that map onto the committee's priorities for population health, it was decided that strategic planning efforts would be better served by developing a set of program components that are supported by the research rather than by selecting specific programs to include in the report. The result of this work is a regionally relevant rubric by which funders (e.g. health systems, state and federal agencies, etc.) can select programs to support for implementation in the communities of Southwest Virginia and Northeast Tennessee. Higher success and greater impact is expected if only programs are selected that employ the following approaches to affecting tobacco use and pulmonary health, physical activity and nutrition, and healthy aging.

The committee expects that the result of their work will not only help meet the goal of interrupting the cycle of inter-generational poor health in the region, but will have economic benefits achieved by encouraging efficient spending toward only evidence-based prevention programs. The following set of evidence-based methods will best be utilized in conjunction with rigorous program evaluation and outcome measurement to ensure a flexible and dynamic approach to prevention in the region's communities.

Tobacco use and pulmonary health

The committee recommends programs that prevent tobacco use initiation in the adolescent population, adult cessation, and pregnancy smoking cessation efforts. The first two are part of the CDC's recommendations for comprehensive tobacco control, while the third was identified as a regional priority due to high prevalence of tobacco usage in pregnant women. In the following sections, approaches supported by the research are described under each of the tobacco and pulmonary health priorities.

I. Adolescent smoking prevention

- A. K-12 school-based, evidence-based smoking prevention education
- B. Media campaign targeting youth smoking prevention and current smokers

II. Adult smoking cessation

- A. Smoke-free legislation – local ordinances, local businesses becoming smoke free
- B. Increase price of cigarettes - at county, city and state level
- C. Smoking cessation counseling referrals offered by primary care physicians

III. Pregnancy smoking cessation

- A. Clinician assisted cessation through referral
- B. Media campaign targeting pregnant smokers
- C. Prenatal and antenatal interventions

I. Adolescent smoking prevention

In order to prevent smoking in adults it is vital to implement programming that targets youth and adolescent populations. This is supported by research showing that nearly 9 out of 10 current daily smokers report trying their first cigarette before age 18, and that only 1% report starting after the age of 26.¹

A. K-12 school-based, evidence-based smoking prevention education²

Effective school-based smoking prevention programs that employ social reinforcement, developmental, and social norms interventions have been proven effective in reducing smoking initiation. These programs are often peer-led and focus on the development of skills to resist social pressures as well as the immediate social and physical consequences of tobacco use. Components of school-based prevention programs can include:

- Group discussion
- Behavioral modeling
- Role playing
- Public commitment not to use tobacco

When developing school-based interventions careful assessment of primary behavioral, normative, and control beliefs must be conducted in order to tailor the approach to the needs of the target audience.²

B. Media campaign targeting youth smoking prevention and current smokers

According to the U.S. Surgeon General, mass media campaigns are valuable for advising the public, including youth, about the hazards of smoking and at encouraging specific cessation actions and services.³

The National Cancer Institute's has stated that mass media campaigns can:⁴

- Discourage youth from starting to smoke
- Encourage adults to quit
- Change attitudes about tobacco use
- Work against tobacco marketing to reduce consumption
- Increase population/political support for tobacco policy change

These campaigns are best done as part of comprehensive tobacco control program. Among media vehicles, there is strongest evidence supporting the effectiveness of television. These interventions can change knowledge, beliefs, attitudes, and behaviors around tobacco use. Economic evidence shows mass-reach health communication interventions are cost effective, and savings from averted healthcare costs exceed intervention costs.^{5,6}

In addition to mass-reach health communication, mobile phone-based cessation interventions have been shown to be effective. These use interactive features to

deliver evidence-based information, strategies, and behavioral support directly to tobacco users interested in quitting. Typically, participants receive text messages that support their quit attempt, with the message content changing over the course of the intervention. With this type of program, the content can be tailored to the population and may include text responses provided on demand to participants encountering the urge to smoke. This can be implemented in conjunction with internet-based cessation services and/or provision of medications.⁵

II. Adult smoking cessation

A. Smoke-free legislation – local ordinances, local businesses becoming smoke-free

Smoke-free policies are recommended as effective strategies for reducing:

- Exposure to secondhand smoke
- Population prevalence of tobacco use
- Initiation of tobacco use among young people
- Healthcare costs
- Tobacco-related morbidity and mortality

Perhaps most dramatic is the evidence linking smoke-free legislation with a decrease in both preterm births and hospital admissions for asthma.⁷ These policies have also been shown to not have a negative financial impact on affected businesses, including bars and restaurants. As of 2012, 26 U.S. states plus Washington, D.C. have enacted comprehensive 100% smoke-free indoor air laws covering restaurants, bars, government and private worksites. However, twelve states, including Tennessee and Virginia, have laws or court decisions pre-empting local smoke-free air laws in government or private worksites or restaurant settings that are more restrictive than statewide ordinances.⁵

B. Increase price of cigarettes – at county, city and state level

Increasing the unit price of tobacco products has been effective in decreasing tobacco use and can be done at the federal, state, or local level. To implement tax on tobacco products, the most common policy approach is legislative which involves imposing fees on tobacco products at the point of sale. Studies on the impact of raising the unit price for tobacco products has shown that a 20% price increase can decrease total consumption of tobacco products by 10.4%, prevalence of adult tobacco use by 3.6%, and initiation of tobacco use by young people by 8.6%.⁵

A. Smoking cessation counseling referrals offered by primary care physicians

The five A's framework (ask, assess, advise, assist, arrange) can be used by physicians to encourage smoking cessation.⁸

- **Ask** patients about tobacco use.
- **Assess** for patient motivation to quit at each appointment.

- Advise patients to quit smoking by using motivational interviewing practices for patients who are not yet ready to stop smoking.
- Pharmacological Assistance is also recommended and should be offered to aid in quitting.
- Arrange for follow-up to provide positive reinforcement.

Each contact with the patients should encourage him or her by highlighting the rewards and significance of quitting, as well as the risks of smoking and expected obstacles to quitting.

III. Pregnancy smoking cessation

The rate of mothers reporting they smoked during pregnancy in the region ranged from approximately 20% to 38% in 2014.⁹ The outcomes associated with tobacco use during pregnancy can be dire for newborns, making this issue of utmost importance for the region.

A. Clinician assisted cessation through referral

The five A' framework (ask, assess, advise, assist, arrange) described in the previous section can be effective in encouraging pregnant women to quit smoking. Implementation of the framework can be aided through the establishment of a few standard protocols:

- Programming reminders in the EMR system to screen for tobacco use
- Having a standardized multiple-choice question to ask patients about smoking status
- Recording smoking status as a vital sign for each patient

Providers can also educate patients about the health benefits of quitting smoking, assist them with choosing a quit date, and/or write a “prescription to quit”. A referral to a cessation program such as a quit line or another resource can assist in this type of intervention. Patients and providers should also discuss the development of a quitting contract as well as talking points for interacting with patients’ friends and family.¹⁰

B. Media campaigns targeting pregnant smokers

According to a report by the U.S. Centers for Disease Control and Prevention, media messaging targeted at pregnant women should focus on the health risks to the unborn child, a life that is highly valued by the mother and those around her.¹¹ Effective programs recognize the stress that pregnant women are under and create compassionate messages that support them in their quit efforts rather than shaming them or utilizing fear tactics.¹¹

C. Prenatal and antenatal interventions

Population-based strategies for tobacco control are needed to reduce smoking initiation among women of child-bearing age. Some approaches include:

- Increasing unit price of tobacco
- Preventing sales of tobacco to young people
- Developing policies to ban smoking in public places
- Workplace smoking cessation programs
- Bans on tobacco sponsorship

When developing interventions, it is important to avoid stigmatization by focusing broadly on parents rather than depicting mothers who smoke as irresponsibly harming their infants. The objective is to assist women in developing alternative coping strategies to deal with living in difficult circumstances.¹² Research has shown that psychosocial interventions can effectively support women as they attempt to stop smoking during pregnancy by improving their psychological well-being.¹² Any psychosocial support should include multiple or tailored intervention components such as incentives, positive feedback, and peer support. Incentives in particular have a significant impact on cessation, but only when provided in conjunction with counseling and social support interventions.¹²

Physical activity and nutrition

Both Northeast Tennessee and Southwest Virginia are experiencing high prevalence of obesity and obesity-related health outcomes (e.g. high blood pressure, stroke, cardio-vascular disease, diabetes, etc.). This, of course, is a national epidemic requiring concerted and comprehensive approaches. Described below are the committee's recommendations for increasing physical activity and improving nutrition in the region's population.

- I. School-based physical activity policy and programming
 - A. K-12 education about diet, exercise and overall health
 - B. Mandatory physical education (PE) in schools for students grades K-12
 - C. Professional development/capacity building for teachers and school administrators
- II. Worksite-based physical activity and nutrition support programs
 - A. Structured educational and support programs related to diet and exercise offered to employees
 - B. Individually-adapted health behavior programs
- III. Community-based physical activity and nutrition programming
 - A. Media campaigns to promote consistent messages related to importance of physical activity and nutrition
 - B. Point-of-Decision prompts
 - C. Built environment to promote physical activity

I. School-based physical activity policy and programming

School systems in the region struggle to meet recommended, and in some cases, legislatively mandated requirement for physical activity in the schools. Delivering physical activity programming in the schools can be highly effective due primarily to their access to the entire youth population.

A. K-12 education: diet, exercise and overall health⁵

For K-12 education, program changes should include developing and executing a well-designed PE curriculum and providing teachers with appropriate training. Programs may be combined with other school and community-based interventions such as health education activities that foster family involvement and community partnerships to increase opportunities for physical activity.

Suggested targets for successful programming:

- Enhance school curricula to include physical activity, nutrition, and body image education.
- Increase opportunities for physical activity and development of movement skills during school time.
- Improve nutritional quality of food in schools.
- Create a culture that promotes healthier foods choices and being active during the day.
- Implement professional development and capacity building activities for teachers and staff.
- Give more attention to parent support and at-home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen-based activities.

Interventions to reduce obesity may vary in effect depending on the age of the child, due to differences in metabolism, nutritional needs, physical maturation, and psychosocial development.

B. Mandatory PE in schools for students grades K-12

Meeting recommended benchmarks for school-based physical education (PE) requires curricular and practice-based efforts that increase the amount of time that K-12 students engage in moderate or vigorous-intensity physical activity. Tennessee's physical activity law requires students to receive at least 90 minutes per week of physical activity during the school day.¹³ Virginia regulations require at least 150 minutes of physical activity per week on average during the school year.¹⁴ Physical activity programs can include any combination of:

- Physical education classes
- Extracurricular athletics
- Other programs and physical activities deemed appropriate by the local school board

During the 2013-14 school year, 85% of all Tennessee school systems reported to the Office of Coordinated School Health that they were compliant with the 90-Minute Physical Activity law for all students. Only 56% of all school districts, however, reported physical activity other than walking between classes in their middle schools. This rate was 30% in high schools.^{13,14} Concern that physical education programs will take away from time spent on academic endeavors is not supported by the research that shows small improvements in overall school achievement, improved mathematics and memory test scores, and improved 'problem-solving' thinking skills among students who engage in recommended daily physical activity during school.⁵

C. Professional development for teachers and school administrators

When implementing school-based interventions, it is important to provide teachers with appropriate training, support, and evaluation feedback. Well-designed professional development can help PE teachers increase the amount of time students spend in physical activity, and decrease the amount of time spent on administrative and classroom management tasks. Training teachers on methods to reduce time spent on classroom management, transitions, and administrative tasks can free up time for physical activity. Mentorship of younger PE teachers by more seasoned instructors can provide vital consultation and feedback opportunities to teachers as they develop strategies to increase physical activity during class.¹⁵

II. Worksite-based physical activity and nutrition support programs

Worksite programs that support physical activity and good nutrition help to create a culture of health within the workplace. These efforts can be highly effective to improve the health of employees and often their families as well.

A. Structured educational and support programs related to diet and exercise offered to employees

The U.S. Department of Health and Human Services' Community Preventive Services Task Force recommends that worksite diet and exercise programs include three main components (Figure 1).

- Environmental changes and policy: Modify physical or organizational structures
- Informational messages: Build the knowledge and attitudes needed to inform positive health practices
- Behavioral and social skills approaches: Target individual awareness, self-efficacy, perceived support, intentions, etc. believed to mediate behavior changes

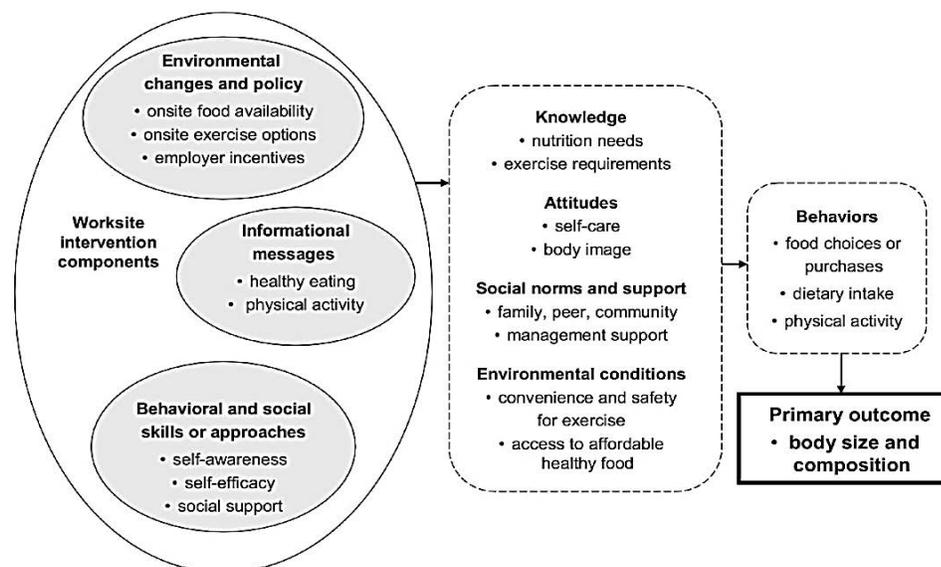


Figure 1. Task Force on Community Preventive Services systematic review of worksite nutrition and physical activity programs, 2009⁵

Worksite programs must be accessible, and require minimal effort to participate, if they are to be successful. The great value of worksite diet and exercise programs is that the population is relatively stable and policies can be much more easily mandated and enforced compared to community-based approaches.⁵ Implemented in conjunction with clinical and community-based interventions, worksite programs can have an impact on overweight and obesity prevalence among employees and the population.

B. Individually adapted health behavior programs

Individually-adapted physical activity programs teach behavioral skills that can help participants incorporate physical activity into their daily routines. They are tailored to an individual's specific interests, preferences, and readiness to change. Effective programs focus on goal-setting, self-monitoring, building social support, behavioral reinforcement, and structured problem solving. Research has shown that these programs increase exercise and improve weight status in children and adults within a variety of settings.¹⁶ Programs that combine professional guidance and self-direction appear to be more effective than programs that do not have professional guidance. Programs can be implemented as independent programs or combined with other interventions.¹⁶

III. Community-based physical activity and nutrition programming

Community-based diet and exercise promotion, combined with school-based and worksite efforts, can help address the health consequences of obesity in the community. Described below is a short list of recommended methods for impacting the community's health.

A. *Media campaigns promote physical activity and nutrition*

Mass media campaigns, as part of multi-component interventions that incorporate individually oriented health behavior change, develop social support networks, and instigate environmental and/or policy changes, can promote physical activity. Media campaigns specifically about the benefits of physical activity and behaviors associated with physical activity can include:

- Consistent messages that promote physical activity through TV, radio, newspaper, direct mail, billboards, posters, trailers in movie theaters, etc.
- Self-help groups, physical activity counseling, risk factor screening at worksites and schools, community health fairs, community events, and creation of walking/biking trails

In addition to increasing levels of physical activity which promotes individual health, communities benefit from the newly generated collective motivation to exercise through the development or strengthening of social networks.⁵ Some challenges that must be considered are coordination among organizations, staff training, and the need for resources. Communities need considerable exposure to consistent messaging in order to change behavior.

B. *Point-of-decision prompts*

Point-of-decision prompts use the routines engaged in by the community to encourage physical activity. For example, a city may build stairs that are inviting and attractive to pedestrians by piping in music, or commissioning an artist to paint a mural on them. In this way, people may choose to walk the stairs rather than take the escalator or elevator. Signage that provides health education

around the benefits of weight loss and reminds the community to be more active may be included in the program.⁵ Point-of-decision prompts have been shown to be effective across a range of settings to increase physical activity in the community.

C. Built environment to promote physical activity

Creation of, or enhancing access to, places for physical activity combined with informational outreach activities is strongly recommended.⁵ Community-scale urban design that promotes physical activity requires the efforts of urban planners, architects, engineers, developers, and public health professionals. Such changes may include:

- Creating walking trails
- Building exercise facilities
- Providing access to existing nearby facilities

To effectively promote physical activity, the built environment should focus on continuity and connectivity of sidewalks, safe and appealing streets, and green spaces within the urban and suburban setting.⁵

Healthy aging

As many of the residents in the region live in rural areas where access to services (healthcare and otherwise) is limited, the committee deemed it important to provide recommendations on how to ensure that communities provide adequate support as people age. Described below is a set of approaches to ensuring healthy aging that account for the living environment, care-coordination, and end of life management.

- I. Community support systems
 - A. Aging in place
 - B. Supportive services and participation in community
 - C. Increased health literacy for elderly adults
 - D. Increased housing options for elderly adults
- II. Chronic disease self-management programs
- III. End of life
- IV. Coordinated care/case management
- v. Patient-centered medical homes

I. Community support systems

In order to ensure healthy aging in the region, it is important to first understand the characteristics of what is referred to as a “livable community.” The American Association of Retired Persons (AARP) has developed a set of indicators that together create a composite measure they call the Livability Index. The measures included in the index are:¹⁷

- Housing: accessibility and affordability
- Neighborhood: shopping, parks, mixed use, crime, jobs, etc.
- Transportation: public transit, safe streets, accessibility of transit
- Environment: water and air quality
- Health: access and quality of prevention and clinical services
- Engagement: civic and social involvement
- Opportunity: employment, education, age, diversity

The Grantmakers in Aging group has developed a framework for making movement toward the livable community and ensuring age-friendly communities. The five steps of the framework are:¹⁸

- Build public will: Identify champions and foster citizen commitment
- Engage across sectors: Be inclusive and engage with a variety of organizations
- Utilize metrics: Make work compelling by identifying and measuring metrics
- Secure resources: Identify “backbone” organization and seek diverse funding opportunities
- Advance age-friendly public policies, practice, and funding

A. *Aging in place*

Aging in place means people are able to live in their home or community of their choice as they age. The most successful aging in place strategies recognize and build on integrated health and social services, and incorporate community and housing design features that help achieve “livable communities” for older adults. They also increase availability of alternative modes of transportation and opportunities for safe, regular physical activity. Aging in place requires design features in new home construction to increase accessibility, usability, and safety for all household members.¹⁹ Figure 2 below was developed by the Stanford Center on Aging and MetLife to illustrate how characteristics of a livable community can contribute to an individual’s ability to age in place.

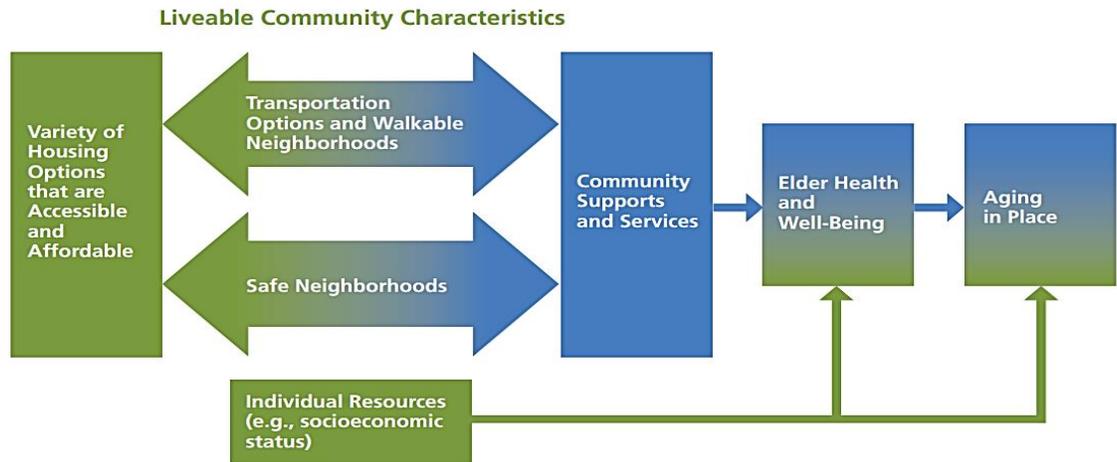


Figure 2. Aging in place and livable communities¹⁹

Community support, such as home repairs and other chores, home health aides, home-delivered meals, and age-friendly transportation, is essential for aging adults to continue living in their own homes. Limited income, mobility, and shopping opportunities can make it difficult for older adults to get proper nutrition. Community gardens, rideshares to grocery stores, home-delivered meals, and efforts to reduce food insecurity make communities more age-friendly.¹⁹

B. Supportive services and participation in community

Older adults who know about the availability of supportive services are more likely to be able to age in place. Some example of services to be incorporated for healthy aging support include the presence of home-and community-based services such as home health care, meals on wheels, and adult day care. Community participation is an important aspect to life as people age. The existence of activities and events that promote inter-generational contact such as places of worship, community centers, social organizations, libraries, museums, and colleges/universities have been beneficial in increasing participation in the community. Volunteer opportunities like tutoring, mentoring, foster grand-parenting, inter-generational programs, social advocacy, and volunteering in schools and religious, community, and nonprofit organizations also help keep older adults engaged, while the community benefits from their experience.¹⁹

Regular exercise lowers the risk of disease and illness in adults over 65. Age-friendly walking and exercise groups in the community can get older people up and moving. To encourage physical activity in the older population, communities must consider elements of walkability which can include longer crossing signal times, better curb cuts, good sidewalk repair, and safe places to stop mid-crossing. One indicator of walkability is whether the city or town planning and/or public works department has approved Complete Streets policies and infrastructure changes. Complete Streets policies typically include three principles:

- Reduce vehicle travel speed;
- Improve the physical layout of streets; and
- Enhance visual cues and information for drivers and pedestrians.

One senior physical activity program is the Senior Olympics, which promotes healthy lifestyles for seniors through fitness, sports, and an active involvement in life.²⁰ Events that seniors are able to compete in for the Olympics include:

- Basketball
- Bowling
- Golf
- Horseshoes
- Pickleball
- Shuffleboard
- Swimming
- Table Tennis
- Tennis

- 5K running

Tennessee and Virginia both have licensed Senior Olympics organizations that compete regionally and nationally.^{20,21}

C. Increased health literacy for elderly adults

Health literacy is the ability of an individual to acquire, process, and comprehend basic health information in order to make appropriate health decisions. Elderly and low-income populations are the most at-risk for low health literacy. Nearly 9 of 10 adults have trouble using everyday health information. Low health literacy is associated with being more likely to skip necessary medical tests, end up in the emergency room more often, and have a difficult time managing chronic diseases. Methods for improving health literacy include streamlining health education materials (written, video, audio, and computer formats), refining patient-provider communication, and improving overall literacy. Evidence suggests that successful health literacy programs include group-based education programs in primary care settings, classes that teach participants how to access health information on the Internet, and increasing self-efficacy in health information seeking.²²

D. Increased housing options for elderly adults

Housing that is accessible, affordable, and adaptable to changing needs over the life span is a critical component of a livable community. Forty percent of older adult households report struggling with the cost of their housing.¹⁹ Age-friendly alternatives include “Golden Girls” home sharing, multigenerational housing, and subsidized senior housing with supportive services.

The common housing unit in the U.S. does not contain age-friendly physical features (e.g. zero-step entrance, wider doors and wider hallways, bathroom on the ground floor, etc.) that improve accessibility and/or visibility. Making age-friendly home modifications can prevent depression and fear of accidents, back injuries, falls and caregiver stress, as well as decrease Medicare expenditures by having a positive effect on physical health.¹⁹

II. Chronic disease self-management programs

Evidence-based chronic disease self-management programs (CDSMP) are community-based approaches that provide education and support around topics including:

- Coping skills for:
 - Frustration
 - Fatigue
 - Pain
 - Isolation
- Physical education for improving strength, flexibility and endurance
- Appropriate use of medications
- Nutrition
- Decision making
- How to evaluate new treatments

The program can involve meetings lasting 2 ½ hours per week for six weeks in small group settings that are held in senior centers, churches, libraries, and hospitals. These workshops are often facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves. Participants in one CDSMP showed increased exercise, cognitive symptom management, communication with physicians, and self-reported general health, as well as lowered health distress, fatigue, disability, and social/role activities limitations.²³

The Tennessee Department of Health offers a program called Living Well with Chronic Conditions, similar to the program described above, in Carter and Johnson counties, among others. According to the Stanford Patient Education Research Center, there are currently 25 master-level trainers in Tennessee and 55 master-level trainers in Virginia.²⁴

III. End of life

End of life is defined as a stage of life when an individual is living with an illness that will continually worsen and ultimately cause death. In order to meet the physical, psychological, social, and practical needs of patients and caregivers at the end of life, palliative care is provided, focusing on preventing suffering and improving quality of life. When working with patients at the end of life, clinicians frequently assess and treat for pain, shortness of breath, and depression. For patients with cancer, this may include several types of pharmacological interventions and/or psychosocial interventions. Clinicians should confirm that advance care planning, including completion of advance directives, occurs for all patients with serious illness.²⁵

IV. Patient-centered medical homes

The patient-centered medical home (PCMH) is best described as a model or philosophy of primary care that is comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It has become a widely accepted model for how primary care should be organized and delivered throughout the health care system, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are. Studies have shown a PCMH provides better support and communication, creates stronger relationship with providers, and saves time for the patient.

The National Committee for Quality Assurance has six broad standards for a PCMH:²⁶

Standard 1: Enhance patient access and continuity

Standard 2: Identify and manage patient populations

Standard 3: Plan and manage care

Standard 4: Provide patient self-care support and community resources

Standard 5: Track and coordinate care

Standard 6: Measure and improve performance

V. Coordinated Care - Case Management

Care coordination and case management programs serve patients across different settings, encouraging communication and interaction among an interdisciplinary team, the patient, and informal caregivers. Effective care coordination programs integrate significant in-person interaction with patients and their caregiver, preferably where the patient lives. Considerations when creating a care coordination plan include ready access by the interdisciplinary team to timely care delivery data, especially in regard to hospital admissions. This yields the greatest quality of care enhancement and reduced cost.²⁷

Case management most importantly includes a comprehensive assessment of the client's health and psychosocial needs, including health literacy status, and uses this information to develop a care plan collaboratively with the client, family, and/or caregiver. The majority of case management is planning, facilitating coordination, and educating the client, family, and members of the health care delivery team about all aspects of the management plan. This includes treatment, insurance, quality of care improvement, and cost-effectiveness.²⁸

Measuring success

The metrics below are expected outcomes from the work described above. There are likely to be other benefits associated with addressing the Population Health and Healthy Communities steering committee priorities, but what is included here is what the committee feels represent the positive outcomes that are expected.

Tobacco use and pulmonary health

Focus Area	Selected Interventions	Metric	Source
Adolescent Smoking Prevention	K-12 Evidence-based Smoking Prevention Programming	Reduction in Incidence and Prevalence of Youth Smokers	YRBSS
	Mass Media Campaign	Youth Smoking Rates Decreased Number of Youth Who Ever Tried Smoking	YRBSS
	Smoke-free Legislation – Local Ordinances, Local Businesses are Smoke Free	Decreased Asthma Rates	BRFSS
Adult Smoking Cessation	Smoke-free Legislation – Local Ordinances, Local Businesses are Smoke Free	Reduction in Prevalence of Smoking	Survey of Legislation
	Increased Price of Cigarettes	Increased Tax Rates for Cigarettes	Survey of Cigarette Prices
	Smoking Cessation Counseling Referrals Offered by Primary Care Physicians	Decreased Chronic Conditions such as COPD, Lung Cancer, CVD	BRFSS
	Mass Media Campaign	Decreased Adult Smoking Rates	County Health Rankings
Pregnancy Smoking Cessation	Pregnant Smokers Will be Identified by Their Healthcare Providers and Referred to Smoking Cessation Programs.	Births to Mothers Who Smoked During Pregnancy (Kids Count Data) Reduced low birth weight babies (Kids Count Data)	Kids Count Data
	Media Campaign Targeting Pregnant Smokers.		Survey of Local Media

Physical activity and nutrition

Focus Area	Selected Intervention	Metric	Source
School-based	K-12 Education re: Diet, Exercise and Overall Health	Increased Number of Children Consuming Fruit and Vegetables	YRBSS
		Decreased Percentage of Children Who have a BMI greater than 25	YRBSS
			YRBSS
	Mandatory PE in Schools for Students Grades K-12	Increased Number of Children Participating in 60 Minutes of Physical Activity per day	YRBSS
		<i>(TN state law only requires 90 minutes per week)</i>	
Professional Development/Capacity Building for Teachers and School Administrators		Number of professional development trainings related to diet/exercise	
Worksite-based	Structured Educational and Support Programs Related to Diet and Exercise Offered to Employees	Decreased Adult Obesity Rates	County Health Rankings
		Decreased Physical Inactivity	
	Individually-Adapted Health Behavior Programs	Decreased Diabetes Rates	County Health Rankings
Community-based	Media Campaign Promotes Consistent Message Related to Importance of Physical Activity and Nutrition	Increase Physical Activity Among Adults	BRFSS
	Point of Decision Prompts	Increased Number of People who are Consuming Five Fruits and Vegetables Each Day and Making Better Food Choices	BRFSS
	Infrastructure to Promote Physical Activity	Increased Access to Exercise Opportunities	County Health Rankings
	Community Social Support Interventions	Decreased Number of Adults who have a BMI of 25 or Higher	BRFSS
		Reduction in Obesity Related Deaths (Region)	CDC Wonder

Healthy aging

Focus Area	Selected Intervention	Metric	Source
Chronic Disease Management	Elderly Adults will be Identified by Primary Care Providers and Offered a Chronic Disease Management Program.	Decreased Preventable Hospital Stays	State-Senior Health Rankings
Transportation	Expanding Services	Increased Vaccination Rates for Elderly	State-Senior Health Rankings
Community Engagement	Increased Activity Programs and Resources for Elderly Adults (e.g. Senior Olympics, AARP Walkable Communities)	Increased Exercise for Persons over 65	State-Senior Health Rankings
		Increased Access to Grocery Stores for Elderly	USDA
Case Management	Increased Health Literacy for Elderly Adults re: Utilizing Resources	Decreased Hospital Admissions (State)	State-Senior Health Rankings
	Increased Housing Options for Elderly Adults		

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Research and Academics Steering Committee

Chairs

Dr. Wilsie Bishop, Vice President of Health Affairs and COO, East Tennessee
State University

Jake Schrum, President, Emory & Henry College

Research and Academics Steering Committee

Last Name	First Name	Organization	Title
Bishop	Dr. Wilsie	East Tennessee State University	VP for Health Affairs and COO
Calvert	Linda	Northeast State	Director, WIA Grant & Bridge
Campbell	John	AccelNow	Executive Director
Campbell	Dr. Steve	Northeast State	VP for Business Affairs
Carmack	Duffy	Southwest VA Higher Ed Center	CFO/ Interim Director
Clark	Dr. Andy	ETSU	Professor of Clinical Nutrition, Associate Dean of Research and Clinical Practice
Collins	Dr. Cathie	UVA Wise	Chair, Dept. of Nursing
Dawson	Dr. B. James	Lincoln Memorial University	President
Dishner	Dr. Nancy	Niswonger Foundation	President & CEO
Drinnon	Dr. Joy	Milligan College	Director of Undergraduate Research/Professor of Psychology
Duncan	Dr. Bill	ETSU	Research & Sponsored Programs
Ehret	Charlene	James H. Quillen Vets Administration Medical Ctr	Director
Fincher	Dr. Lou	Emory & Henry	Dean, School of Health Sciences
Fowlkes	Rachel	Southwest VA Higher Ed Center	Retiring Director
Gilliam	Dr. Janice	Northeast State Community College	President
Grandy	Joe (William)	Ferguson	General Manager
Greer	Dr. Bill	Milligan College	President & CEO
Henderson	Rebecca	Strategic Priorities Consulting	Consultant
Henry	Donna	UVA Wise	Chancellor
Kendall	Martha	Johnston Memorial Hospital	Speech / Language Pathologist
Khoury	Dr. Amal	ETSU – Public Health	Chair, Dept of Health Svcs Mgt & Policy
Linville	Dr. David	ETSU	Associate Dean for GME
Lugo	Dr. Ralph	Gatton College of Pharmacy ETSU	Professor and Chair of Pharmacy Practice
Lura	Dr. Richard (Dick)	Milligan College	Professor of Chemistry
Mayhew	Dr. Susan	Appalachian School of Pharmacy	Dean
Means	Dr. Robert (Bob)	ETSU, Quillen College of Medicine	Dean
Mitchell	Dr. Kathy	Virginia Highlands Community College	Dean, Nursing & Allied Health
Moody	Dr. Nancy	Tusculum College	President
Moorman	Dr. Jon	ETSU	Vice Chair, Research & Scholarship/Residency Program Director
Nida	Dr. Maurice	Wellmont Health System	Head of family medicine residency program with LMU
Phillips	Dr. Kenneth	ETSU	Interim Assoc. Dean, Research
Pope	Pat	QSource (Quality Improvement Network for State of TN)	Practice Solution Advisor
Prill	Dr. Sue	Wellmont Cancer Center	Medical Director, Breast Center
Ray	Dr. Richard	King University	Interim President
Rhinehart	Dr. Andrew	Glytec	Chief Medical Officer

Last Name	First Name	Organization	Title
Schrump	Jake	Emory & Henry	President
Shipley	Lindsey	ETSU Quillen College of Medicine	Student (Joint MD/MPH program)
Stepanov	Dr. Nonna	Mountain States Health Alliance	Director of Research
Tillman	Dr. Ken	ETSU - College of Nursing	Associate Dean of Academic Programs
Tooke-Rawlins	Dr. Dixie	Via College of Osteopathic Medicine	
Walker	Clay	NETWORKS Sullivan Partnership	CEO

EXECUTIVE SUMMARY

Research and Academics Steering Committee

The Research and Academics Steering Committee focused its energies primarily on exploring collaborative opportunities to help maximize the impact of the proposed regional health system “Newco” on health and economic growth in Northeast Tennessee and Southwest Virginia. The committee concluded that a unified healthcare system working collaboratively with the regional academic institutions offers a unique and unprecedented opportunity to impact the health and economic well-being of the region by: 1) bolstering the academic training and supply of qualified health professionals; and 2) supporting research programs that enhance healthcare services and community interventions targeting priority health issues. The Committee’s overall objective was to propose a research and academics partnering strategy between Newco and regional academic institutions that facilitates collaboration and ultimately leads to improved population health, access to health care services, and economic gains in Northeast Tennessee and Southwest Virginia. To meet this objective, committee members worked to:

- Identify **opportunities and challenges** for collaboration between the proposed regional health system and academic institutions to further research and health professions education
- Identify **existing institutional strengths** to address identified population health workforce needs of the region
- Develop an **organizational structure** to facilitate an integrated research and academic enterprise between the proposed regional health system and the region’s academic institutions

The target region for the committee’s work was the 21-county catchment of Mountain States Health Alliance and Wellmont Health System, which serves a population of over a million. Many of the counties in the region are designated rural/non-core, meaning they are sparsely populated and not near the center of a metropolitan area. Health-related social factors such as poverty, food insecurity, transportation challenges, and housing insecurity are more prevalent in rural populations, which makes serving these communities uniquely challenging to health systems. In their Certificate of Public Advantage / Cooperative Agreement Pre-Submission Report to Tennessee and Virginia released in January of 2016, Mountain States and Wellmont committed to making the proposed merged system “a national model for rural healthcare delivery and rural access to care.”

The committee determined that a collaborative infrastructure that recognizes area institutions with health science programs can vastly improve efforts to meet the health needs of the region through education, research, and training. To that end, the committee proposes separate research and academic oversight councils (Health Education and Training Council and Research Institute) populated with representatives from member institutions. These bodies will be coordinated by a joint Research and Academic Coordinating Council that will provide input and guidance by interfacing with the health system and other funding organizations. The outcomes of this approach will include fewer programmatic redundancies across institutions, better coordination of student flow through clinical and non-clinical training sites, greater efficiency in meeting the region’s health workforce needs, and coordination of research efforts to improve the health of the region.

A major area of focus for the committee was assuring that the region provided the variety and complexity of health training programs to meet the workforce needs of the region. The development of a program inventory along with an understanding of how the two health systems currently work with educational programs provided a basis for discussions of ways to facilitate collaboration and coordination of programming going forward.

The second area of focus was identification of strategies to respond to the population health research needs of the region and identifying an infrastructure to do so. It was recognized that the other steering committees would be identifying specific areas of research focus, so this committee discussed how to structure the research endeavor in a way that would seek maximum synergy from the existing two health systems while drawing on the research areas of strength of ETSU and the other institutions in the region. A focus on establishing research centers provides a way to bring together existing resources, be competitive in securing federal and other research dollars, and focus on efforts within local communities to prevent and treat poor health outcomes.

As the proposed merger should bring about a reduction in the duplication of services and provide a more cost-effective healthcare delivery system, the recommendations from this steering committee project an infrastructure to facilitate collaboration and synergy in the delivery of education and training, as well as offer a model for translational research and clinical trials endeavors that will provide opportunities for growth and improvement to the health and well-being of our local communities.

Opportunities and challenges for collaboration between the proposed regional health system and academic institutions

In order to allocate funds to develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline of nurses and allied health professionals, the committee agreed that a collaborative organizational structure must be conceived to facilitate communication and the coordination of efforts. Members identified barriers and opportunities to the development of this collaboration so they may be part of the strategic planning process moving forward.

Opportunities

Through the process of exploring opportunities for new research and academic partnerships between the proposed merged health system and regional academic institutions, the first steps toward collaboration were taken by the deans, presidents, and other academic leaders interested in improving and building academic health sciences in Appalachia. This informal network, developed over the course of the six months in which meetings were held, will serve as the basis for a collaborative structure between these institutions and the proposed merged health system. The result will be greater opportunity for innovations in health sciences research and academics to benefit surrounding communities for generations to come.

The proposed merged health system represents opportunities for improved coordination and quality of health services in the region through the development of a large health information database, as well as formal mechanisms for collaboration with academic partners providing health science training. Public documents released to date confirm the committee's expectations that the proposed merger will result in the generation of new resources and commitments for education and research. This commitment will increase the ability of academic institutions to meet training needs by partnering more efficiently with facilities within the new health system.

A single large health system can help align the workforce geographically to better provide health care to surrounding communities. In addition to aligning resources for improved program efficiency, the availability of large databases within a single system will facilitate opportunities for training in health services research, healthcare economics, healthcare policy research, and outcomes research. The quality of education within each individual program will be improved through partnership with the new system by more effectively engaging different disciplines for synergy in training, and creating opportunities for academic partners to share teaching resources (for example, simulation labs and technical support).

The region has a rich diversity of educational programs and institutional characteristics that currently attract large volumes of applicants, demonstrating a high level of interest in health care as a profession. Better training coordination and student flow through practice sites, which is an expected outcome of the proposed merger, should encourage recruitment and retention of graduates to work in the region. The region is at the fore of inter-professional health sciences education nationally, making it an attractive option for prospective students from across the country and elsewhere. With a merged health system serving such a large rural population, combined with the expertise of its higher education institutions, the area is poised to become a national hub for training, innovation, and cross-discipline professional development.

The region has benefited from a high level of investment and dedication from various stakeholders toward the health and well-being of area communities. With the proposed merger there will be enhanced opportunities to benefit from both Tennessee and Virginia state governments' interest in investment for novel approaches to regional health challenges. Existing efforts toward cross-sector collaboration with academic partners in the region (e.g., Healthy Appalachia Institute at UVA-Wise; Tennessee Institute for Public Health, Academic Health Departments, and Tennessee Public Health Training Center at ETSU) can serve as seeds for coordinated and more inclusive collaboration between the new health system and academic institutions.

Through increased efficiency and diversity of programming, the academic partnership across institutions and within the health system can help retain the large number of individuals interested in pursuing healthcare careers in the region post-graduation. Development of a unified strong message promoting the region to prospective health science students and faculty can be achieved through consensus building and work toward a common agenda. Academic programs can then be grown and developed in conjunction with efforts to map training onto identified community needs.

Challenges

There is no doubt that many challenges face the hospital systems and their academic partners as each attempts to innovate the existing system for health sciences training in the region. Planning, infrastructure building, implementation, and surveillance efforts will require collaborative input from all parties involved on an ongoing basis if they are to be successful.

Currently the regional healthcare institutions are not able to accommodate the large number of applicants for healthcare training positions. One contributing factor is the challenges faced in recruiting high-level faculty and clinical specialists to the region, due in part to the lack of employment opportunities for applicant spouses. Development of a shared human resources job database aimed at facilitating spousal employment could potentially address this issue and improve recruitment and retention of clinical providers and health science faculty within the region. Past experience suggests it is far easier to train professionals to live and work in the region than it is to recruit them.

Communication across institutions currently does not encourage sharing of resources to support the delivery of coordinated academic training or the execution of collaborative research. Improving communication between health science programs can prevent institutions from having to "reinvent the wheel" and allow them to draw on shared resources to support their programming. Each individual institution has limited resources, and the development of new and coordinated programs will require outside funding and effective management of that funding in a deliberate and rigorous manner. Due to regulatory considerations and institutional governance procedures, it takes time to transform educational programs.

The process of establishing partnerships across academic institutions, many of whom consider themselves in competition with each other, is fraught with barriers and challenges. Add in coordination with a new merged health system working to establish new infrastructures and protocol for the management of a large number of health facilities, and the process becomes more complex and tenuous. Strategic planning must include leadership from academic partner institutions, including those with the experience and ability to enter into agreements with outside entities. Initial planning should include a communication structure that explicitly states the routes of communication within a specified schedule, as well as a staffing structure to support such endeavors.

Institutional strengths to address identified population health workforce needs of the region

Fourteen regional institutions participated in discussions around collaboration with the proposed merged health system, representing over a hundred certificate and degrees programs, training more than 13,000 students in the region annually. Table 1 below lists these programs and their parent institutions along with enrollment.

Table 1. Health-related degree programs and enrollment within partner institutions

Regional Institution	Program	Enrollment	Academic Year
Appalachian College of Pharmacy	Doctorate in Pharmacy (3 year program) (75 students per year) (225 Total Students)	75	2015-16
Edward Via College of Osteopathic Medicine	Third Year Students	24	2015-16
	Third Year Students	30	2016-17
	Fourth Year Students	24	2015-16
	Fourth Year Students	30	2016-17
	Residency Programs in MSHS-Johnston M. (originally sponsored by VCOM)	7	2015-16
	Residency Programs in MSHS Johnston M.	19	2016-17
	Residency Programs in MSHS Johnston M.	31	2017-18
Emory and Henry College	Residency Programs in MSHS Johnston M.	36	2018-19
	Doctor of Physical Therapy (DPT)	32	2015-16
	Master of Occupational Therapy (MOT)	25	2016-17
East Tennessee State University	Master of Physician Assistant Studies (MPAS)	30	2016-17
	Social Work	329	2015-16
	Clinical Psych	25	2015-16
	Bachelor of Public Health (BS)	150	2015-16
	Master of Public Health (MPH)	131	2015-16
	Doctor of Public Health (DrPH)	27	2015-16
	PhD Environmental Health	3	2015-16
	MS Environmental Health	3	2015-16
	Nursing (BSN)	684	2015-16
	Pre-Nursing	512	2015-16
	Nursing (MSN)	328	2015-16
	Doctor of Nursing	104	2015-16
	Nursing BS (Pre-licensure students, RN to BSN)	473	2015-16
	Nursing RN to BSN	206	2015-16
	Doctorate in Pharmacy	76	2015-16
BS in Pharmacy Studies	16	2015-16	
BS Health Sciences	270	2015-16	

Regional Institution	Program	Enrollment	Academic Year
East Tennessee State University	BS Environmental Health	47	2015-16
	Graduate Certificate in Epidemiology	12	2015-16
	Health Care Management Certificate	21	2015-16
	Tennessee Students	277	2015-16
	Residency Programs	258	2015-16
	Research Center	55	2015-16
	Biomedical Sciences (PhD)	36	2015-16
	Cardiopulmonary Science (BS)	42	2015-16
	Radiography (BS)	64	2015-16
	Dental Hygiene (BS)	48	2015-16
	Nutrition and Foods (BS)	37	2015-16
	MS in nutrition	20	2015-16
	MS in Allied Health	26	2015-16
	Speech Pathology (MS)	59	2015-16
	Audiology (AuD)	35	2015-16
Physical Therapy (DPT)	106	2015-16	
King University	Nursing (BSN)	436	2015-16
	Nursing (MSN)	182	2015-16
	Doctoral Nursing Program	11	2015-16
Lincoln Memorial University	Nursing	571	2015-16
	Counseling	34	2015-16
	Veterinary Medicine	196	2015-16
	Social Work	9	2015-16
	Nurse Anesthesia Program	41	2015-16
	Doctor of Nursing Practice (DNP)	6	2015-16
	Master of Science Nursing (MSN)	148	2015-16
	Bachelor of Science Nursing (BSN)	213	2015-16
	Associate of Science Nursing (ASN)	358	2015-16
	Doctor of Osteopathic Medicine (DO)	893	2015-16
Master of Medical Science in Physician Assistant Studies (MMS)	278	2015-16	
Milligan College	Nursing (RN, BSN)	149	2015-16
	MS in Occupational Therapy	95	2015-16
	Master of Counseling	26	2015-16
	Bachelors of Social Work	5	2015-16
Mountain Empire Community College	Emergency Med. Serv.	18	2015-16
	Health Inf. Mgmt.	46	2015-16
	Nursing (AAS Degree)	126	2015-16
	Respiratory Therapy	33	2015-16

Regional Institution	Program	Enrollment	Academic Year
Mountain Empire Community College	Practical Nursing (Certificate)	59	2015-16
	EMT – Intermediate	30	2015-16
	EMT- Paramedic	4	2015-16
	Health Sciences	281	2015-16
	Nursing Assistant	57	2015-16
	Pharmacy Aide	48	2015-16
	Phlebotomy	33	2015-16
Northeast State Community College	Pre-Nursing	191	2015-16
	Pre-Occupational Therapy	16	2015-16
	Pre-Pharmacy	27	2015-16
	Pre-Radiography	127	2015-16
	Pre-Cardiopulmonary	10	2015-16
	Pre-Dental Hygiene	70	2015-16
	Pre-Med Tech	3	2015-16
	Dental Assisting	47	2015-16
	Med. Lab. Tech.	64	2015-16
	Surgical Tech.	52	2015-16
	Office Admin. Tech.	87	2015-16
	Cardiovascular Tech.	86	2015-16
	Nursing (AAS)	1,442	2015-16
	Pre-Occupational Therapy (AS-TTP)	13	2015-16
	Pre-Physical Therapy (AS-TTP)	86	2015-16
	Pre-Health Prof. (AS-TTP)	72	2015-16
	Dental Assisting	30	2015-16
	Emergency Med Tech (TCP)	27	2015-16
	EMT-Paramedic (TCP)	32	2015-16
	Southwest Virginia Community College	Nursing (RN, AAS)	90
Allied Health Programs (LPN)		12	2015-16
Paramedic 1 st Year		22	2015-16
Paramedic 2 nd Year		5	2015-16
EMT		7	2015-16
Radiology Tech 1 st Yr.		9	2015-16
Radiology Tech 2 nd Yr.		2	2015-16
Occup. Therapy Asst. 1st Year		26	2015-16
Occup. Therapy Asst. 2nd Year		26	2015-16
CNA		31	2015-16
Phlebotomy		13	2015-16
Pharmacy Tech		12	2015-16
AAS Mental Health Services, Substance Abuse		34	2015-16

Regional Institution	Program	Enrollment	Academic Year
Southwest Virginia Higher Education Center	BSN Nursing	29	2015-16
	MSN Nursing	12	2015-16
	CRNA	22	2015-16
	Doctorate Nursing Admin.	2	2015-16
	MLT	9	2015-16
	ICD Coding	15	2015-16
Tusculum College	BSN and RN to BSN	103	2015-16
University of Virginia's College at Wise	BSN Nursing	108	2015-16
	Pre-Medical/Dental/Veterinary	133	2015-16
Virginia Highlands Community College	Nursing (RN, AAS)	124	2015-16
	Radiology Tech	12	2015-16
	CNA	40	2015-16
	EMT/Paramedic	26	2015-16
	Occupational Therapy Assistant	16	2015-16
	Health Inf. Mgmt. Certif.	30	2015-16
	Electronic Health Records Certificate	5	2015-16

Collaborative Research and Academic Organizational Structure

The following section describes the structure and objectives of the proposed collaborative research and academic organizational structure. The committee recognizes this proposal is the beginning of a discussion on the best way for regional institutions to partner with each other and the proposed merged system. Successful collaboration will require ongoing communication and planning between partner institutions.

Mission/Summary

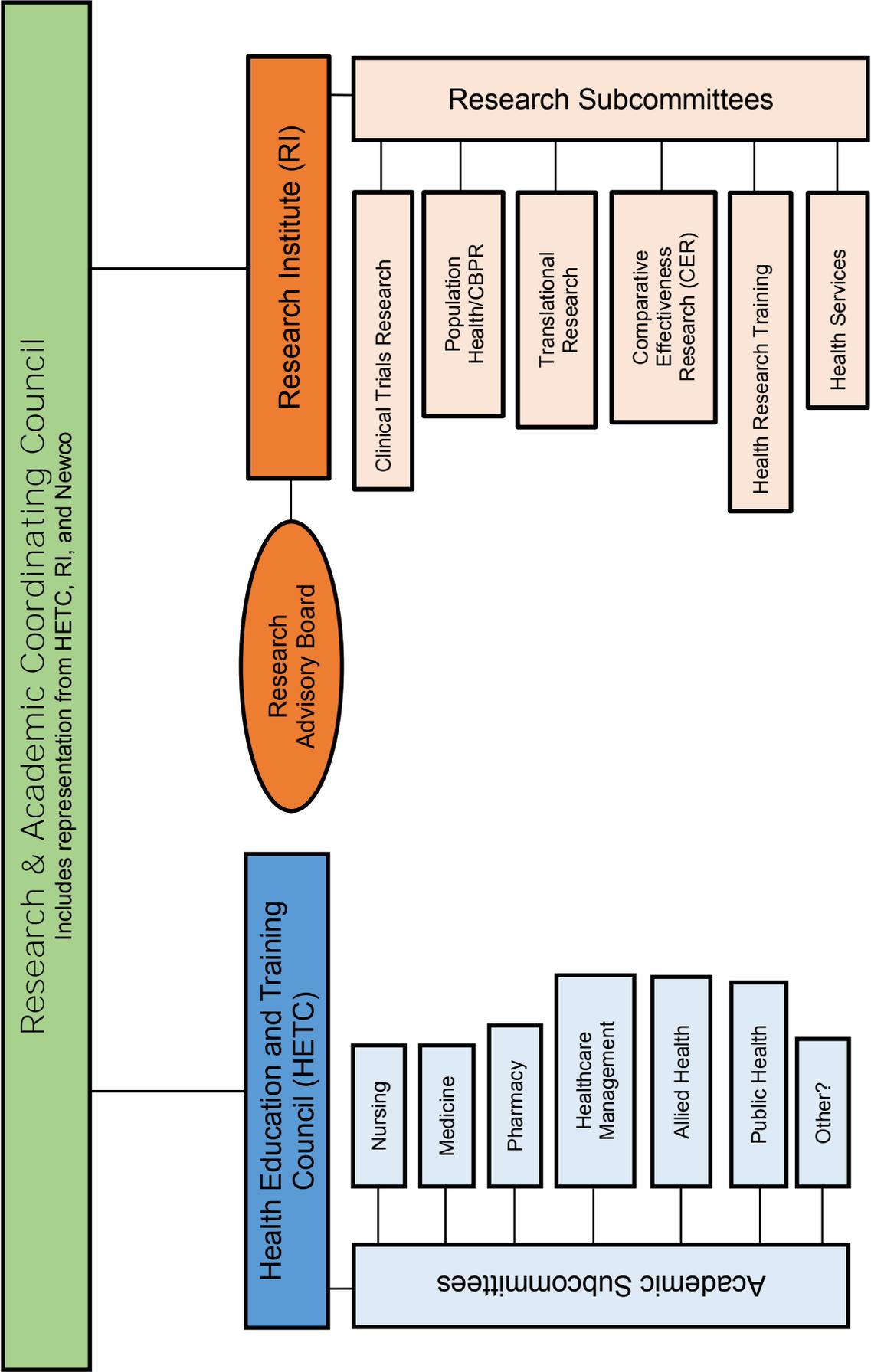
The Research and Academics Steering Committee concluded that a unified health system Newco, working collaboratively with the regional academic institutions, offers a unique and unprecedented opportunity to impact the health and economic well-being of our region by: 1) bolstering the academic training and supply of qualified health professionals and 2) supporting research programs that enhance health care services and community interventions targeting priority health issues. To maximize the impact of the proposed merged health system on health and economic growth in Northeast Tennessee and Southwest Virginia, the committee proposed a partnership strategy between Newco and regional academic institutions aimed at facilitating collaboration, ultimately leading to improved population health, access to health care services, and economic gains in the region.

The proposed partnership structure will be overseen by a Research and Academic Coordinating Council whose mission will be to improve health and health care in the NE Tennessee and SW Virginia region through provider training and the advancement of medical knowledge through patient and population oriented research targeting priority health needs. The Research and Academic Coordinating

Council will establish the strategic vision and plan for the partnership and will guide, coordinate, and support its two primary arms: the Health Education and Training Council and the Research Institute. **All proposed bodies will include representation from Newco and its academic and research partners.**

The Health Education and Training Council (HETC) will serve as the formal advisory board for Newco to help advance health professional training and student internships, leading to increased supply and diversity of the healthcare workforce in the region. The HETC will be responsible for coordinating student placements, identifying workforce needs and program development, and facilitating transition to employment with Newco. The HETC will include several academic subcommittees, each representing a major discipline and responsible for managing collaborative efforts, shared resources, and learner placement within that discipline. The academic subcommittees will represent nursing, medicine, pharmacy, public health, healthcare management, allied health, and any other discipline as deemed necessary.

The Research Institute (RI) will establish a robust collaborative research infrastructure between Newco and its research partners, leading to improvements in healthcare delivery, patient outcomes, and population health. The RI will be responsible for identifying and prioritizing research initiatives, identifying and seeking external funding, and assuring high-quality research performance and compliance. The RI will include several research subcommittees representing high priority research focus areas: clinical trials research, population health/community-based research, comparative effectiveness research, health services research, translational biomedical research, and health research training. The RI, through its subcommittees, will facilitate research that is highly relevant to the Appalachian region to enhance access to, and the effectiveness of, healthcare services, as well as to promote our understanding of the factors that impact our population's health and policies and to evaluate programs that can lead to significant and sustainable health improvements.



Research & Academic Coordinating Council

Mission

To enhance health care in the region through provider training and the advancement of medical knowledge through patient and population oriented research.

Purpose

- To review and assess recommendations from HETC and RI
- To develop and implement benchmark performance metrics for HETC and RI members
- To establish overall strategic vision and plan for overall partnership

Health Education and Training Council (HETC)

Mission

To maximize the effective use of Newco resources to meet the health professional training needs of the region.

Purpose

- Facilitate communication between academic partners toward enhancing health training
- Act as liaison between academic partners and the R&A Coordinating Council
- Develop and implement coordinated system for placing students in training sites
- Develop and implement protocols for ensuring quality practice experience for students at training sites

Research Institute (RI)

Mission

To establish a robust collaborative research effort between Newco and its regional academic partners, leading to improvements in health care delivery, patient outcomes, and population health

Purpose

- Identify and prioritize key research initiatives to address major health issues of the region.
- Identify and seek external funding opportunities
- Facilitate the funding requests and the receipt of funds between Newco and academic partners
- Facilitate development of interdisciplinary research collaboration between Newco and regional academic institutions.
- Maintain an administrative, legal and financial infrastructure assuring high quality research performance and compliance.

Research & Academic Coordinating Council

The Research & Academic Coordinating Council shall provide oversight and guidance to the academic and research partnership formed between Newco and regional academic institutions. The Research & Academic Coordinating Council shall ensure mission alignment between Newco and academic/research efforts to improve health in the region.

Membership The number of voting members of the Research & Academic Coordinating Council shall be thirteen (13) or such other number as may be designated by resolution of a majority of the members of the Research & Academic Coordinating Council, provided that the number of voting members shall not be more than fifteen (15) nor less than five (5).

Health Education and Training Council

The Health Education and Training Council will serve as the formal academic advisory board for Newco with representation to be determined from the academic institutions which place learners in the Newco system facilities. The Health Education and Training Council will be responsible for coordinating student placements, identifying workforce needs and program development, and facilitating transition to employment into the Newco system.

Membership The number of voting members of the Health Education and Training Council shall be six (6) or such other number as may be designated by resolution of a majority of the members of the Health Education and Training Council, provided that the number of voting members shall not be more than nine (9) nor less than five (5).

Academic subcommittees

Academic subcommittees will be developed for a minimum of six disciplinary areas in order to manage specific learner placement and integration into Newco facilities. Those six areas include:

- Nursing
- Medicine
- Pharmacy
- Allied health
- Public health
- Healthcare management

Other academic health science subcommittees may be designated by resolution of a majority of the members of the Health Education and Training Council.

Membership The number of voting members of each academic subcommittee shall be dictated by the number of programs actively training students in the partner institutions or such other number as may be designated by resolution of a majority of the members of the Health Education and Training Council, provided that the number of voting members shall not be more than seven (7) nor less than three (3).

Research Institute

The Research Institute shall establish a robust collaborative research network between Newco and its regional academic partners, leading to improvements in health care delivery, patient outcomes, and population health.

The RI will have a central office with a staff dedicated to providing administrative support to the institute. Such assistance is anticipated to include organizing and coordinating institute meetings; coordinating and facilitating progress reporting for the institute and institute researchers; disseminating information regarding research funding opportunities to researchers at Newco and academic partners; managing and assisting with research application flow to the institute; disseminating institute research findings to institute researchers, institute leadership, academic partners, and the community; coordinating educational events specifically linked to institute mission; providing monthly post-award accounting of grant balances to funded institute researchers; maintaining the institute's website; and developing and disseminating announcements to the media.

Health research training is anticipated to be of major importance to the overall mission of the RI. Researchers funded through RI mechanisms, as well as RI partners and advisors, will contribute to the education and training of graduate, pharmacy, medical, nursing, physical therapy, audiology, public health, and other health disciplines that are represented among the academic partners of the institute. The RI will advance the development of a diverse workforce that will engage in research dedicated to the mission of the institute and that is of critical importance to the region's health. The RI could additionally fund students and/or fellows specifically focused on health research issues deemed to be of high priority by the RI leadership and advisory council and could fund beginning/younger researchers on projects that are specifically focused on priority areas.

Membership The number of voting members of the Research Institute shall be nine (9) or such other number as may be designated by resolution of a majority of the members of the Research Institute, provided that the number of voting members shall not be more than eleven (11) nor less than five (5).

Research Advisory Board

This body would be expected to include administrative and scientific leaders from Newco and the regional academic partners and leading medical science advisors external to the region. The Advisory Council would be responsible for providing assistance to identify the research priorities of the institute, and for assuring progress and productivity of funded researchers.

Membership The number of voting members of the Research Advisory Board shall be six (6) or such other number as may be designated by resolution of a majority of the members of the Research Advisory Board, provided that the number of voting members shall not be more than nine (9) nor less than five (5).

Research subcommittees

The research subcommittees shall be responsible for the coordination of efforts across academic institutions in their respective areas of focus.

Membership The number of voting members of the Health Education and Training Council shall be five (5) or such other number as may be designated by resolution of a majority of the members of the Health Education and Training Council, provided that the number of voting members shall not be more than seven (7) nor less than three (3).

Clinical trials research

The RI Clinical Trials Office (CTO) would provide a centralized clinical research support system to all interested investigators practicing at Newco, including faculty at ETSU and other associated academic centers, as well community physicians. The CTO would provide end-to-end professional services to investigators conducting clinical trials, including: identification of potential studies; support for contract and budget development and negotiation for industry-sponsored trials; clinical research associates to assist in the collection of protocol-specific documentation of patient information; clinical research coordinators and nurses to assist the investigator in conducting the trials; regulatory support, including filing documents with the FDA and IRB; and oversight of billing compliance.

Population health research

Population health research focuses on the health outcomes of groups of individuals, e.g., workers at a workplace, residents of a neighborhood, people sharing a common demographic or

social status, or the population of a region (for example, those living in rural areas). Population health studies attempt to characterize the levels and distributions of health within and across populations; analyze the impact on health of different underlying factors, including biologic, genetic, behavioral, social, and environmental influences and their interactions among individuals and groups and across time and generations; and evaluate the effectiveness of community-based interventions. Access to the large patient population in the Newco healthcare system will enhance the potential of RI funded investigators to attract substantial research funding from federal and non-federal agencies with an interest in supporting research to improve population health, especially in a rural environment. Newco's collaboration with local public health agencies will further enhance community-based research leading to population health improvement.

Comparative effectiveness research

Comparative effectiveness research (CER) compares the benefits and harms of different strategies to prevent, diagnose, treat or monitor health conditions, and deliver health care in the "real world" settings. Newco will be one of the largest health care systems in Tennessee with more than 100,000 discharges/year and one of the largest academic health systems in a rural setting in the U.S., with three strong regional clinical research hubs – Johnson City Medical Center, Bristol Regional Medical Center, and Holston Valley Medical Center. Access to this large patient population will enhance the potential of RI funded investigators to attract substantial research funding from federal (AHRQ) and non-federal agencies (PCORI) with an interest in supporting research to improve health outcomes. Potential areas of RI support for CER are the identification of prevention, diagnosis and treatment options that work best to reduce the burden of disease in Appalachia (including addiction, diabetes and obesity, CVD, and cancer) and the development of new approaches to address disparities across patient populations to achieve best outcomes in each population.

Health services research

Health services research (HSR) uses health systems, as well as patient and population-level data, to better inform the delivery of health services, improve quality of care and patient outcomes, and support the creation and tuning of policies, processes, and management systems for health improvement. Examples of HSR include: assessing patterns of health service utilization and costs; identifying health system-level approaches to improving access and care coordination for vulnerable populations; identifying and implementing patient-centered, evidence-based interventions in clinical practice and adapting interventions according to population and setting; and evaluating how health policy and services impact patient outcomes and population health. Newco will offer a comprehensive electronic health record, administrative, and other real-time data to support HSR that directly impacts practice. The RI will enhance HSR through access to data, funding, and support for recruiting health services researchers to complement the available expertise at ETSU and other partners. Potential areas of RI support for HSR include: care coordination for multiple chronic illnesses; patient care transitions between hospitals, nursing homes and their own homes; impact of novel services (e.g. patient navigation, telehealth) on rural and high-risk population groups in Appalachia, innovative use of health information technology, and modeling policy and payment options in the

region. RI funded researchers will be highly competitive for funding from NIH, AHRQ, PCORI, private foundations, and the industry.

Translational biomedical research

The RI will enhance translational biomedical research activities by providing support for the collection, preparation, and long-term storage of clinical samples as well as clinical data from patients at Newco facilities and physician offices throughout the region. The development of these valuable resources, which are currently rare in this region, can be used by basic biomedical researchers to support $T_0 - T_1$ discovery research. It is anticipated that the availability of these resources would greatly facilitate a transition of activities of regional biomedical scientists to research focused on clinical application. The field of sepsis is an example of an opportunity to pursue translational biomedical research between ETSU biomedical scientists and the clinical programs at Newco. Both hospital systems have strong clinical programs in the area of sepsis, and ETSU has three NIH basic biomedical grants to study sepsis that would benefit from increased access to patient samples and clinical data.

Health research training

Health research training is anticipated to be of major importance to the overall mission of the RI. Researchers funded through RI mechanisms, as well as RI partners and advisors, will contribute to the education and training of graduate, pharmacy, medical, nursing, physical therapy, audiology, public health, and other health disciplines that are represented among the academic partners of the institute. The RI will advance the development of a diverse workforce that will engage in research dedicated to the mission of the institute and that is of critical importance to the region's health. The RI could additionally fund students and/or fellows specifically focused on health research issues deemed to be of high priority by the RI leadership and advisory council and could fund beginning/younger researchers on projects that are specifically focused on priority areas.



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

November 22, 2016

Robert E. Cooper, Jr.
Bass Berry & Sims PLC
150 Third Avenue South, Suite 2800
Nashville, TN 37201

Claire Cowart Haltom
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
P.O. Box 190613
Nashville, TN 37219

Re: Meeting Follow-up and Request for Information

Dear Mr. Cooper and Ms. Haltom:

We hope you found last Wednesday's meeting informative. We wanted to follow up expeditiously to summarize the key messages from our conversation and outline a path moving forward.

As a point of clarification, the experts with whom we all met did not, as you know, have access to the confidential information submitted by the applicants under the Attorney General's Civil Investigative Demand process. While some of their comments clearly showed that they were not aware of that confidential information, our purpose in having the meeting was to have disinterested third-parties in this field, whom the department has consulted on a very limited basis, review relevant portions of the application and provide feedback on the issues involved in transitioning from a traditional fee-for-service acute care hospital model, which is the primary current state of your clients' businesses, to a population health care management model with Triple Aim goals that is anticipated by the Hospital Cooperation Act.

Additionally, we want to affirm to you that, because the Department has deemed the application complete, there are not, strictly speaking, any "gaps" in the application but rather what the Department has determined are deficiencies in the information provided in the application. The issue that concerns the Department is whether the information presented is sufficient to

determine whether the “clear and convincing” standard, as required by Tennessee law, has been established. It is this issue that we hope you can address by reviewing the following comments.

First and foremost, as you understand, to the extent that the application must be supplemented, as the potential regulator under a Certificate of Public Advantage that might be issued for your clients, the Department cannot tell you exactly what to include in the application or any supplemental materials. Neither can we be your strategist for implementing a change in your business model, in part because that position is outside of the scope of the Department’s role as the regulator but also because that area is not within the Department’s realm of expertise. However, we can advise you that any new materials submitted must detail your clients’ internal plans and capacity to carry out these plans. To the extent possible, the Department is willing to review outlines of potential responses to ensure the Department’s concerns are adequately addressed.

Broadly stated, the Department must see a clear, detailed plan to move a potentially combined system forward that demonstrates that the proposed merger is likely to provide a long-term, sustained benefit to the public beyond the traditional fee-for-service acute care hospital model. It is the Department’s position that the benefits outlined in the statute contemplate improvements managed by the applicants in the areas of population health, access/quality, and cost (the “Triple Aim”), rather than a commitment to provide funds to third parties to provide any benefits. To the extent that money will be spent, the Department must be convinced that these investments will result in meaningful outcomes. Stated differently, the Department must see detailed information in regard to how the investments will be realized outside of the mere commitment to dedicate funding to specified programs.

Moreover, to the extent that commitments outlined in the application are intended to mitigate the negative impacts of a loss of competition, the Department must be convinced that these commitments will have the desired impact.

What follows summarizes some of the feedback provided on Wednesday and includes a non-exhaustive list of identified issues that your clients may use as a guide to address the Department’s concerns.

- Define your strategy to move from the historic-fee-for service environment to managing health.
 - Move from hospital centric model to a person and community centric model
 - Articulate a roadmap to move through the “risk corridor” described on Wednesday
 - Define the change management plan that will guide the transition
- Define insurance and value payment transition.
 - Evaluate and create plan for Triple Aim performance for a targeted population (Medicaid)

- Create the short and long term strategy to move through the corridor and define the changing payer / risk relationship
- Define structure for the future
 - Structure for true clinical integration encompassing all parties
 - Align incentives for value creation
 - Align providers for value creation
- Define the comprehensive regional strategy to deliver equitable and efficient care
- Define and plan for the new infrastructure
 - Create short and long term strategy for the new infrastructures to the support system
- Define the performance measurement system
- Provide cultural alignment plan
- Describe how to build the new clinical system
 - Define the new care team models to achieve results
 - Build the plan for coordination of care across the continuum including community resources
- Define IT strategy
 - Create the roadmap for the IT strategy
 - Define the new analytics engine and how it will support the population health framework
 - Define IT governance structure

Your application could be furthered strengthened by providing detail on the following items:

- Evidence-based and/or empirical data to justify a residential treatment center as the best intervention to address substance abuse in the region.
- How you plan to partner or collaborate with community organizations.
- The evidence-based research that supports the population health plan, current regional penetration of these programs, and how the new approach will differ from current activities and investments.

Regarding the last bullet point above, we have not provided suggestions regarding population health improvement efforts; however we encourage you to review the most recent update to the State Health Plan (titled: “2015 Update to the State Health Plan.” found at <http://tn.gov/health/article/state-health-plan>) for information on the Department’s interest in primary prevention activities and the need to improve the four major health issues identified therein. Additionally, you should know that the Tennessee General Assembly has charged the Department with the development of a statewide Oral Health Plan, and that the Northeast Tennessee area experiences some of the worst oral health in the nation.

While we anticipate providing you additional information in this area in the near future, the Department is interested in your clients' plans for comprehensively addressing population health challenges and setting outcome goals and timelines.

Additionally, based on confidential information provided in supplemental application materials provided by your clients, the sale by one of your clients to a for-profit entity would have resulted in the establishment of a foundation of at least comparable size to the funds proposed in the application for community benefits. And as has been stated by your clients, the sale of one system would more than likely eventually result in the sale of the second system, potentially resulting in an additional foundation. Thus, the Department believes the amount and timing of funding proposed by your clients should not be considered as a basis for an advantage that would accrue to the region as a result of a COPA-facilitated merger. In addition, the Department, as part of its duty to actively and strongly supervise should a COPA be granted, reserves the right to reallocate or adjust the categories and amount of the intended financial outlays, within the limits of the total stated commitment.

Our final advice is that we want to restate and reinforce the comment made during the meeting last Wednesday that, in terms of additional commitments that may be offered, the mere mitigation of existing disadvantages does not result in cognizable benefits or advantages. The Department further believes that mere mitigation would unlikely rise even to a preponderance of evidence standard.

To the extent that any information you plan to submit needs to remain confidential, please immediately contact Deputy Attorney General Janet Kleinfelter for instructions on how to submit that information to the Attorney General's Office.

Finally, nothing in this letter should be construed to imply that the Department has made a decision on the application.

We look forward to continued conversation regarding this application.

Sincerely,



Jeff Ockerman
Director, Division of Health Planning

c: Jane Young, General Counsel
Malaka Watson, Sr. Assistant General Counsel
Janet Kleinfelter, Deputy Attorney General



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH**

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

February 29, 2016

Alan Levine
President & CEO, Mountain States Health Alliance
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Bart Hove
President & CEO, Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660

Re: Request for Addendum in Response to the January 25, 2016 Letter

Dear Mr. Levine and Mr. Hove:

The Tennessee Department of Health requests that the applicants provide an addendum to the application for the issuance of a Certificate of Public Advantage, COPA, submitted February 16, 2016, that specifically addresses the observations and positions raised in the January 15, 2016, letter from the department written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report." To the extent that your application addresses the stated observations in the application, please specify the location in the application and note how the information provided responds to the department's observations and positions.

Further questions about the application process can be directed to me at allison.thigpen@tn.gov and/or 615-253-9979.

Sincerely,

A handwritten signature in blue ink that reads "Allison Thigpen".

Allison Thigpen, MPH | Health System Improvement Coordinator
Division of Health Planning

Cc: Valerie Nagoshiner
Malaka Watson
Jeff Ockerman



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

January 15, 2016

Bart Hove
President & CEO, Wellmont Health System
1905 American Way
Kingsport, TN 37660

Alan Levine
President & CEO, Mountain States Health Alliance
303 Med. Tech Parkway, Suite 300
Johnson City, TN 37604

Dear Mr. Hove and Mr. Levine:

Thank you for submitting a copy of the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report" (report) prepared by Wellmont Health System (WHS) and Mountain States Health Alliance (MSHA) for public information and education, pursuant to Tennessee Department of Health Rule 1200-38-01-.02. The Department of Health (department) acknowledges and appreciates the effort of the two organizations to provide information to the public regarding the proposed merger.

The intent of the initial observations below is to provide guidance regarding information the department will need to evaluate the application and/or to clearly note the department's position regarding certain facts. To the extent this information is or will be provided in the actual application to the department or through means established to submit proprietary and confidential information to the office of the Attorney General, you may disregard our observations.

Observation #1 - Geographic Service Area

The report does not include counties in Kentucky and North Carolina in the geographic service area while the Letter of Intent, submitted September 16, 2015, does include these counties.

Department Position:

Consistent with department rule, "[i]f the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the application, a description of how and why the proposed geographic area differs and why changes are proposed" is required.¹

¹ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)7



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The department notes the Kentucky and North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance.² Unless the application, when it is submitted, includes a reasonable justification to exclude the Kentucky and North Carolina counties, the department will consider these counties, which are contiguous to counties with facilities of the New Health System, to be included in the service area.³

Observation #2 - Prevention Services for all Categories of Payers

The description in the report of prevention services for all categories of payers lacks detail. For example, substance abuse prevention is the only specific example provided.

Department Position:

It is the department's position that, for the application to be deemed complete, prevention services will need to be more specifically enumerated. Consistent with department rule, the Cooperative Agreement must detail the "[p]roposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements..."⁴

Observation #3 - Equity

The explanation of how the New Health System will provide equitable health services with respect to maintaining quality and competition within the service area needs further explanation.⁵ The department acknowledges the report includes a discussion of access to services in rural areas.

Still, the document primarily focuses on contracts with health plans and does not discuss the impact of the proposed merger on other payers and their respective populations, including Medicaid and Medicare populations and people without insurance.

Department Position

Consistent with department rules, the application should include policies that specifically address Medicaid and Medicare populations and people without insurance.⁶ Moreover, the population health improvement plan detailed in the application should cover all residents in the geographic service area.

² For example: Mountain States Health Alliance. (2013). Form 990: Return of Organization Exempt from Income Tax. (OMB No 1545-0047). Part III, Line 1: Statement of Program Service Accomplishments. Retrieved January 13, 2016, from <http://990finder.foundationcenter.org/>. [See PDF pg. 177.]

³ These counties include the following: Harlan, KY; Letcher, KY; Ashe, NC; Avery, NC; Madison, NC; Mitchell, NC; Watauga, NC; Yancey, NC.

⁴ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix)(II)

⁵ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)12(iii)

⁶ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(vii)(III)III[A-D]



STATE OF TENNESSEE
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JOHN J. DREYZEHNER, MD, MPH
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Observation #4 – Health of the Region and Population Health Disparities

The identification and discussion of population health disparities is limited. While the report briefly highlights differences in health behaviors and outcomes among geographic entities, the report does not discuss other groups that often experience health disparities, *e.g.*, racial/ethnic minority, rural and urban, age and gender disparities. The department also notes the report does not address physical activity, one of the Tennessee State Health Plan “Big Three + 1” health issues (physical inactivity, obesity, tobacco use and substance abuse). As you know, evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health.

Department Position

For an application to be deemed complete, granular detail is needed regarding factors that influence the health and health disparities of counties, communities, and groups within them, particularly as it relates to the applicants’ current assessment of existing trends and long-term population health outcomes.

The department also notes that, should a COPA be issued, the New Health System will be responsible for population health in the region for an indefinite period of time. The department is interested in additional longitudinal plans and New Health System expectations for regional population health improvement after the initially-proposed ten year period.

Observation #5 – Duplication of Services.

As noted in the report, MSHA and WHS currently have “expensive duplications of costs” and plan to reduce duplications post-merger through delivery model integration and “job displacement.”⁷ Limited detail of these plans is provided.

The department also notes that most other hospital mergers (including the merger of St. Joseph’s Hospital and Memorial Mission Hospital in 1995 supervised by the State of North Carolina through a COPA) result in the reduction of the number of full-time equivalent positions.

Department Position:

Pursuant to department rule, the application must include “economic metrics that detail anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement.”⁸

To ascertain how efficiencies in operating costs and shared services could potentially impact population health and health care, the department needs additional detail to evaluate the potential

⁷ Wellmont Health System and Mountain States Health Alliance. Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report. January 2016. p. 8-9.

⁸ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix)



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benefits and disadvantages of these plans to achieve these cost savings. Specifically, the department will require a good faith estimate of the number of full-time equivalent positions estimated to be eliminated each year, or if none, other plans to achieve stated efficiencies.

Observation #6 – Reinvestment of Cost Savings

The report does not state whether the estimated \$450 million re-investment of cost-savings is a conservative or optimistic projection. The report also does not allow the reader to discern the estimate of the intervals and amounts of savings and subsequent reinvestments planned over the proposed ten year period.

Department Position

To allow the department to evaluate this aspect of public benefit, the application should include a good faith estimate of the expected annual expenditures in each reinvestment category that will be realized each year.

The department understands the document you submitted is a pre-submission report and that you may already be planning to include these further details in the actual application. The department wishes to alert you to these observations in the event you had not anticipated and addressed them in the application. In the event they are not included, the department will be amenable to the applicants' submitting an addendum after filing the application.

Further questions about the application process can be directed to me at allison.thigpen@tn.gov and/or 615-253-9979.

Sincerely,

Allison Thigpen, MPH | Health System Improvement Coordinator
Division of Health Planning



December 22, 2016

400 N. State of Franklin Road • Johnson City, TN 37604
423-431-6111

Herbert H. Slatery III
Office of the Tennessee Attorney General and Reporter
425 Fifth Avenue North
Nashville, TN 37243

Re: Mountain States Health Alliance

Dear Attorney General Slatery:

This notice is provided pursuant to the Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code Annotated, Title 48, Chapter 68, Part 2 (the "Act").

Mountain States Health Alliance ("Mountain States") is a Tennessee nonprofit corporation that qualifies as a public benefit hospital under the Act. Mountain States anticipates entering into a public benefit hospital conveyance transaction within the meaning of the Act. Specifically, Mountain States and Wellmont Health System ("Wellmont") have entered into an affiliation agreement pursuant to which they plan to merge under the umbrella of Newco, a newly formed independent public benefit nonprofit corporation.

Pursuant to Tenn. Code Ann. § 48-68-203, Mountain States certifies that a copy of the Act has been provided in its entirety to each member of its Board of Trustees. Mountain States and Wellmont intend to comply with all requirements of the Act and to cooperate in all respects with your office. We look forward to providing any further information necessary for the Office of the Attorney General and Reporter to assess the proposed transaction.

Sincerely,



Timothy S. Belisle
Mountain States Health Alliance
Senior Vice President
Compliance Officer and General Counsel

cc: Janet M. Kleinfelter, Office of the Tennessee Attorney General and Reporter
Robert E. Cooper, Jr., Bass, Berry & Sims PLC
Ashby Q. Burks, Baker Donelson



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

BILL HASLAM
GOVERNOR

March 28, 2016

Alan Levine
President & CEO, Mountain States Health Alliance
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Bart Hove
President & CEO, Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660

Re: Request for Additional Information (#1)

Dear Mr. Levine and Mr. Hove:

The Tennessee Department of Health (department) is currently reviewing the information submitted on February 16, 2016, in the application for a Certificate of Public Advantage (COPA) submitted by Mountain States Health Alliance and Wellmont Health System (collectively referred to as the parties, individually, a party).

According to state law, a COPA shall be issued if the department “*determines that the applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.*”¹ Further, department rule authorizes the department to “*request additional information from the parties prior to deeming the application complete.*”²

While the department is reviewing the application in its entirety, the department has elected to engage consultants, as authorized by state law, to ensure the department has the specialized expertise required to conduct due diligence in a manner that adequately protects all who may be affected by the proposed merger.³ Prior to the conclusion of the department’s completion review (which will incorporate feedback from the consultant), the department will periodically notify the parties of sections that are incomplete to allow the parties time to prepare supplemental materials.

¹ T.C.A. § 68-11-1303(e)(1).

² Tenn. Comp. R. & Reg. 1200-38-01-.02(3)(a).

³ T.C.A. § 68-11-1307(2)(b).

As you know, it is the responsibility of the parties to provide sufficient information for the department to evaluate the application. During the department's preliminary review, the department found the level of detail and specificity provided by the parties to be insufficient. In this and subsequent letters, the department will identify sections of the application as complete or incomplete. Incomplete shall have one of the following meanings and shall be identified as such:

Incomplete (1): The section is deemed incomplete because the section does not meet the letter of the rule; or

Incomplete (2): The section is deemed incomplete because the information provided is insufficient to determine the advantages and disadvantages of the proposed merger.

INCOMPLETE SECTIONS

1. Cooperative Agreement – Incomplete (1)

Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)13

The “Master Affiliation Agreement and Plan of Integration” by and between Wellmont Health System and Mountain States Health Alliance, dated as of February 15, 2016, (which serves as the Cooperative Agreement required by department rule), does not meet the letter of the rule for the following two reasons:⁴

A. *Counsel Memoranda – Incomplete (1)*

Not included in the application are the “Wellmont Counsel Memorandum” and the “MSHA Counsel Memorandum,” (collectively referred to herein as the Counsel Memoranda), referenced by the Cooperative Agreement in Exhibit 11.1. The Counsel Memoranda likely includes, but is not limited to, information related to subsidiaries, financial statements, liabilities, contracts, tax matters, title to properties, litigation, compliance with law, permits and licenses, real property, environmental protection, insurance, and employees and benefit plans. The department cannot assess the potential impact of the Cooperative Agreement in the absence of the Counsel Memoranda that contains information necessary to understand the potential impact of the Cooperative Agreement.

Please provide a copy of the Wellmont Counsel Memorandum mentioned in the Cooperative Agreement in Article III Sections 3.05 through 3.17 and a copy of the MSHA Counsel Memorandum mentioned in Article IV Sections 4.05 through 4.17.

⁴ *Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)13*

B. *Excluded Information – Incomplete (1)*

The Cooperative Agreement lacks information required by department rule.⁵ At a minimum, the following information was not included in the executed copy of the Cooperative Agreement:

(v) *A description of the competitive environment in the parties' geographic service area, including:*

(I) *Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;*

(II) *The parties' estimate of their current market shares for services and products and the projected market shares if the COPA is granted;*

(III) *A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and*

(IV) *A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.*

(vi) *Impact on the service area's health care industry workforce, including long term employment and wage levels and recruitment and retention of health professionals;*

(vii) *Description of financial performance, including:*

(I) *A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five (5) years including debt, bond rating and debt service and copies of external certified public accountants annual reports;*

(II) *A copy of the current annual budget for each party to the Cooperative Agreement and a three (3) year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;*

⁵ Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)13

- (IV) *Identification of existing or future business plans, reports, studies or other documents of each party that:*
 - I. *Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and*
 - II. *Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.*

- (ix) *A description of the plan, including economic metrics, that details anticipated efficiencies in operational costs and shared services to be gained through the Cooperative Agreement including:*
 - (I) *Proposed use of any cost savings to reduce prices borne by insurers and consumers;*
 - (II) *Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services to achieve long-term population health improvements; and*
 - (III) *Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.*

- (x) *Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the department. Measures should include source and projected trajectory over each of the first five (5) years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:*
 - (I) *Improvements in the service area population's health that exceed Measures of national and state improvement;*
 - (II) *Continuity in availability of services throughout the service area;*
 - (III) *Access and use of preventive and treatment health care services throughout the service area;*
 - (IV) *Operational savings projected to lower health care costs to payers and consumers; and*

(IV) *Improvements in quality of services as defined by surveys of the Joint Commission.*

The department expects parties to a potential merger to be accountable to each other and to the State for the commitments detailed and promised in the application. To this end, these commitments should be included in the Cooperative Agreement pursuant to department rule.

2. Plan of Separation – Incomplete (1)
Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)17

The department's requirement for a plan of separation is to specifically ensure that if a COPA is issued and the New Health System (as defined in the application) fails to live up to the promised commitments and understanding reached by the department and the parties, the department may terminate the COPA and require a clear plan of action to return the parties to a pre-consolidation state. The minimal framework presented in the application does not provide the level of detail necessary to meet the department's requirement to outline a clear, actionable plan to separate a merged entity.

The department will continue its on-going and active review of the application materials submitted thus far, including the recently submitted addendum, while the department waits for a response to this letter and for information considered by the parties to be confidential or competitively sensitive.

Sincerely,

A handwritten signature in blue ink, appearing to read "John J. Dreyzehner", with a small "MD" or similar mark at the end.

John J. Dreyzehner, MD, MPH, FACOEM
Commissioner

cc: J. Richard Lodge
Richard G. Cowart



April 22, 2016

Alan Levine
President & CEO, Mountain States Health Alliance
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Bart Hove
President & CEO, Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660

Re: Request for Information (#2)

Dear Mr. Levine and Mr. Hove:

Thank you for your willingness to work with us on the three priority issues raised in the March 28, 2016, letter from Commissioner John J. Dreyzehner, MD, MPH, FACOEM. The first two items covered information required for the Cooperative Agreement, the legally binding document between Mountain States Health Alliance and Wellmont Health System. Ultimately, if a Certificate of Public Advantage (COPA) is granted, the Tennessee Department of Health (department) will supervise the Cooperative Agreement between the parties to merge. As such, it is imperative that this agreement specify certain information required by department rule, whether or not the information is documented elsewhere in the Application. The third request was for a more detailed Plan of Separation. Since you are amenable to resolving these items, the department is providing this Request for Information (#2).

In the department's view, the Application and Addendum #1 lack the depth required for the department to evaluate a Cooperative Agreement for a merger of this magnitude. Pursuant to state law, "the department shall issue a certificate of public advantage for a cooperative agreement, if it determines that the applicants have demonstrated by *clear and convincing evidence* that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement."¹ As defined by the Tennessee Supreme Court, "[c]lear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the *evidence*."² Where the applicants provide responses to the requirements set forth in the rules, the responses do not provide enough evidence of the claimed benefits presented. Please understand that providing responses to the application requirements without sufficient explanation and documentation does not mean the information is clear, convincing, or complete. Applicants should avoid conclusory responses. As your team compiles the additional information requested

¹ T.C.A. § 68-11-1303(e)(1), emphasis added.

² Hodges v. S.C. Toof & Co., 833 S.W.2d 896, 901 n. 3 (Tenn.1992), emphasis added.

below, be mindful that many of these requests are necessary because the responses in the application and addendum failed to substantiate stated benefits and commitments.

In addition to the foregoing, the applicants must show the “likely benefits *resulting from the agreement* outweigh disadvantages attributable to a reduction in competition.”³ That is, benefits considered by the department in its evaluation must result from the proposed Cooperative Agreement.

As you know, it is the responsibility of the parties to provide sufficient information for the department to evaluate the application. As detailed in the March 28, 2016 letter, the department will identify sections of the application as complete or incomplete. Incomplete shall have one of the following meanings and shall be identified as such:

Incomplete (1): The section is deemed incomplete because the section does not meet the letter of the rule; or

Incomplete (2): The section is deemed incomplete because the information provided is insufficient to determine the advantages and disadvantages of the proposed merger.

Below, the department lists incomplete sections, provides general comments, and notes inconsistencies in application materials. Please use this list in preparing additional information necessary for the department to evaluate the application. This list is not exhaustive and further information will be required. In addition, the department encourages the applicants to revisit the application requirements outlined in the rules.

³ T.C.A. § 68-11-1303(e)(1), emphasis added.

REQUEST FOR INFORMATION (#2)

I. INCOMPLETE (1)

a. Services Offered by Other Providers

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)8

Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:

- i. Limit services and products provided to those within the geographic service area;⁴
- ii. Revise classification of facilities to reflect substitutable services or products;⁵
- iii. Provide information on the structure of physician practices to calculate the appropriate market share.⁶
- iv. Identify physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant.

b. Description of the Competitive Environment

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(v)

Recalculate market shares using appropriate geographic market and output measures.⁷

⁴ Pursuant to department rule, identification of services offered by other providers and the corresponding market share calculations should be limited to the geographic service area identified in the application. The application identifies the geographic service area (GSA) as a 21-county area that includes ten (10) Tennessee and eleven (11) Virginia counties. In contrast, Application Section 6, Exhibit 6, and Addendum #1 Section 3 include products from competitors located outside this 21-county GSA.

⁵ A facility is the method of delivery for the product but is not necessarily itself the product. For example, gastroenterology, orthopedic, and eye surgery centers are not substitutable (i.e., a patient with eye issues would not consider accessing the former two surgery centers). Consequently, these facilities cannot be listed under the same product or used to calculate a market share.

⁶ The market power of a single physician is not equal to the bargaining power of a physician group. Therefore, in Exhibit 6.1-E, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required.

⁷ See Incomplete Item I.a.

c. Cooperative Agreement - EXHIBIT 11.1

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13

- i. Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.
- ii. Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:
 1. Exhibit C-1: Interim Parent Company Articles and Interim Parent Company Bylaws.
 2. Exhibit C-3: Amended Parent Company Articles.
 3. Exhibit C-4: Amended Parent Company Bylaws.

II. INCOMPLETE (2)

a. Potential Disadvantages

Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)3(iv)

Identify any potential disadvantages that may result from the Cooperative Agreement.

b. Geographic Service Area

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)7

Detail whether the New Health System intends to increase its market share in the following counties: Harlan and Letcher in Kentucky; and Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

c. Insurance Contracts / Proposed use of any Cost Savings to Reduce Prices Borne by Insurers and Consumers⁸

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(vii)(III)I, II

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(ix)(I)

- i. Provide the number of current insurance contracts that represent less than 2% of patient services revenue.
- ii. Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system.

⁸ See Application pp. 46 and 47.

- iii. Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currently planned fixed rate increases. You may aggregate these rates separately for MSHA and Wellmont if you include the mean and standard deviation of the planned fixed rates.
- iv. Provide the negotiated rate increases for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician or non-hospital outpatient services by more than the hospital or medical care Consumer Price Index minus 0.25%.
- v. Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.
- vi. Detail how the New Health System will handle price setting for uninsured or private pay patients.

d. Common Clinical IT and Health Information Exchange

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)10

- i. Provide your anticipated 10-year timeline with milestones for development and implementation for both the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. At a minimum, the timeline should include targeted objectives for each year following the formation of the New Health System, including target dates for the following activities:
 - 1. Behavioral health capability. If your chosen Clinical IT system does not currently include a behavioral health module, detail your plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors.
 - 2. Integration of systems and / or linkage of records (medical, lab, pharmacy, diagnostic, and referral / scheduling).
 - 3. Migration and / or archiving of pre-existing records.
 - 4. Training for new users (System and non-System providers).
 - 5. Patient access to information.
 - 6. Capabilities for collecting, analyzing and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers (System and non-System).

- ii. Provide estimates for how and when the \$150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.
- iii. Describe the current commitment and timeframe for participation of both MSHA and Wellmont in OnePartner, the operational regional health information exchange. Also describe the options and plans for future participation (e.g., continued participation or acquisition of OnePartner, participation with a competing HIE provider, or development of a competing service offering).

e. Total Cost Resulting from Cooperative Agreement

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)15

Provide the total amount detailed in the reports from MSHA and Wellmont, referenced in the Master Affiliation Agreement Section 10.04(d), setting forth all Expenses incurred by the parties. Include justification for the above amount. Detail all additional merger-related expenses, including capital costs and management costs. Provide documentation of the availability of the necessary funds.

f. Description of Financial Performance

Tenn. Comp. R. & Regs. 1200-30-01-.02(2)(a)13(vii)

- i. The description and summary of financial performance of Wellmont and MSHA does not adequately detail all components noted by department rule. (See Exhibits 11.4 and 11.5)
- ii. Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the \$75 million investment in population health improvements; 2) the \$140 million to expand mental health, addiction recovery, substance abuse prevention programs; and 3) the \$85 million to develop and grow academic and research opportunities.⁹
- iii. Complete the “Year-by-Year Summary” that requests an estimate of the year-by-year timing of reinvestments and cost savings. (See Attachment 1)

⁹ Requests for additional detail regarding the \$150 million investment in Common Clinical IT and a Health Information Exchange are detailed in Incomplete Section II.d.

- iv. Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on your most recent IRS Form 990 Schedule H.¹⁰
- v. Detail whether a \$75 million investment in population health over ten years represents an increase in spending over that of past community health investment, and if so, provide an estimate of the aggregate planned population health investment.
- vi. Detail whether an \$85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.
- vii. Compare and contrast the type of programs currently funded by Community Benefit spending, particularly in the categories above, with the planned investment over the next ten years.
- viii. Provide the audited financial statement on MSHA as of June 30, 2015. (See Exhibits 11.4-F)
- ix. On April 06, 2015, Fitch Ratings placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of Johnson City, TN, revenue bonds issued on behalf of MSHA and parity debt issued on behalf of MSHA listed in April 06, 2015 press release. Provide the current status regarding Fitch's Rating Watch. (See Exhibits 11.4-H)

g. Efficiencies in Operating Costs and Shared Savings

Tenn. Comp. R. & Regs. 1200-30-01-.02 (a) 13(ix)

Provide the report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger.

III. GENERAL COMMENTS

- a. Detail how an additional layer of governance (i.e., the parent company) benefits the organization.
- b. Provide an organizational chart that shows the resulting institution.

¹⁰ As non-profit hospitals, MSHA and Wellmont already provide some level of community benefit. The department notes that in 2012 MSHA and Wellmont had net expenditures of \$10.8 million on community health improvement and \$18.9 million on health professions education and research.

- c. Clarify the amount of current debt and what is proposed in debt repayment and/or incurring additional debt as a result of this proposal.
- d. Provide details regarding severance packages, including but not limited to, timing of implementation and dollar amount. Include details of severance packages currently being paid. (See Application p. 61)
- e. Provide proposed employment agreements mentioned in the application.
- f. Describe the proposed performance parameters that will be used to measure employee performance.
- g. The resulting board appears to be comprised of nine (9) members, of which only eight (8) will be voting members. Identify and/or detail how the board would deal with a 4/4 vote.
- h. Provide the Physician Needs Assessment from Niswonger Children’s Hospital and detail how recruitment strategy will differ post-merger.

IV. INCONSISTENCIES

The applicants should address the inconsistencies noted below.

<p>Exhibit 11.4, pages 3 and 5 (Adobe pgs. 709 and 711/2578)</p>	<p>The Statement of Operations summary for the fiscal year ended June 30, 2014 did not always appear to agree with amounts presented on the financial statement included in the application (Exhibit 11.4, Attachment F). For example, the summary reported net patient revenue decreased by \$3.8 million; however, the audited financial statement (Adobe pg. 1538/2578) reflected a decrease of \$4.96 million. Additionally, the Balance Sheet summary for the fiscal year ended June 30, 2014 stated that part of the reason for the increase in assets was due to an increase in patient receivables; however, the Consolidated Balance Sheet (page 1536/2578) reflected a decrease in patient accounts receivable of approximately \$3 million from the prior year.</p>
<p>Exhibit 11.5 – Attachment C Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures (as listed on page 126) (Adobe pg. 128/2578)</p>	<p>The exhibit was not included in the application. This exhibit was not included in the list of excluded information on page 119; therefore, it appears to have been omitted from the application in error.</p>

<p>Exhibit 11.8, page 2 (Adobe pg. 2500/2578)</p>	<p>The “Timing and Phases of Efficiency Assumptions” section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE 6/17; however, the “Preliminary Efficiencies” Model Income Statement appeared to reflect savings of \$41,144 over the “Baseline” model for the FYE 6/16 (i.e., savings of \$21,632 in medical supplies and drugs, \$5,651 in purchased services, \$1,002 in maintenance and utilities, and \$12,859 in other).</p>
<p>Exhibit 11.8, page 9 (Adobe pg. 2507/2578)</p>	<p>It appears, for the forecasted columns of the “Baseline” Model Balance Sheet, total net assets should equal the prior year ending net assets balance plus revenues in excess of expenses reported on the operating statement on the previous page. However, the total net assets balances reported on the “Baseline” Model Balance Sheet in the 2016 through 2020 columns did not equal this. The difference appears to be related to the income attributable to non-controlling interests.</p>
<p>Exhibit 11.8, pages 12 and 13 (Adobe pgs. 2510-11/2578)</p>	<p>On the “Preliminary Efficiencies” Model Cash Flows, the cash flows from financing activities included amounts for each year for payments made related to income attributable to non-controlling interest. However, it appears the “Preliminary Efficiencies” Model Balance Sheet on the previous page reflected this amount as part of net assets each year (i.e., the non-controlling interest component of net assets increased each year by the amount of income attributable to non-controlling interest)</p>
<p>Exhibit 11.8 – pages 10 and 13 (Adobe pgs. 2508 and 2511/2578)</p>	<p>The amounts reflected for Payments on LTD and liabilities (net of interest) on the “Baseline” and “Preliminary Efficiencies” Model Statement of Cash Flows were not consistent with amounts disclosed in the debt service schedules presented in the most recent financial statements included in the application. The financial model notes referenced a “Debt Schedule” (page 6) which may provide explanation; however, this schedule was not included with the model. It was expected that the LTD and liabilities payments would agree with debt service amounts presented in the notes to the financial statements (Exhibits 11.4, Attachment F and 11.5, Attachment B) (Adobe pgs. 1559 and 2421/2578).</p>

Sincerely,



Jeff Ockerman | Director

cc: J. Richard Lodge
Richard G. Cowart
John J. Dreyzehner, MD, MPH, FACOEM

Exhibit 11.4

Attachment D

Mountain States Covenant Compliance Certificates

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 1,521
+ Depreciation	\$ 15,089
+ Amortization	\$ 42
+ Interest Expense	\$ 601
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 17,253
Total Debt Service (MAD'S)	\$ 4,323
Debt Service Coverage Ratio	3.99x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 39,318
Minority Interest	\$ -
Unrestricted Net Assets	\$ 272,927
Total	\$ 312,245
Debt to Capitalization Ratio	13%
Covenant Requirement	< 65%

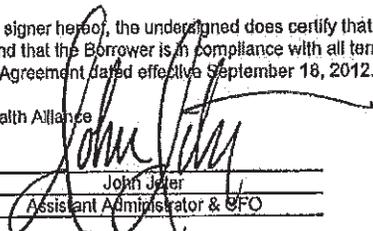
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
 Print Name: John Jeter
 Title: Assistant Administrator & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>18,472</u>
+ Depreciation	\$ <u>11,003</u>
+ Amortization	\$ <u>49</u>
+ Interest Expense	\$ <u>348</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	\$ <u>-</u>
EBITDA	\$ <u>29,872</u>
Total Debt Service (MADS)	\$ <u>4,492</u>
Debt Service Coverage Ratio	<u>6.65x</u>
Covenant Requirement	<u>1.30x</u>

Debt to Capital

LT Debt	\$ <u>36,269</u>
Minority Interest	\$ <u>-</u>
Unrestricted Net Assets	\$ <u>298,268</u>
Total	\$ <u>334,637</u>
Debt to Capitalization Ratio	<u>11%</u>
Covenant Requirement	<u>< 65%</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
Total Operating Expenses (Including Interest)	\$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TTM)	\$ <u>-</u>
Daily Cash Expenses	\$ <u>-</u>
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 6/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 11,448
+ Depreciation	\$ 14,633
+ Amortization	\$ 34
+ Interest Expense	\$ 755
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 24,188
Total Debt Service (MADS)	\$ 5,013
Debt Service Coverage Ratio	4.83x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 39,027
Minority Interest	\$ -
Unrestricted Net Assets	\$ 271,795
Total	\$ 310,822
Debt to Capitalization Ratio	13%
Covenant Requirement	< 65%

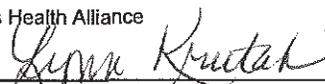
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 12,063
Unrestricted Investments	\$ 105,056
Total Cash	\$ 117,119
Total Operating Expenses (Including Interest)	\$ 134,160
less: Non Cash Expenses	\$ 14,667
Total Cash Expenses (TTM)	\$ 119,493
Daily Cash Expenses	\$ 327
Days Cash on Hand Ratio	358 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Vice President/Corporate CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 8,606
+ Depreciation	\$ 12,798
+ Amortization	\$ 41
+ Interest Expense	\$ 578
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 22,023
 Total Debt Service (MADS)	 \$ 4,321
 Debt Service Coverage Ratio	 <u>5.10x</u>
Covenant Requirement	<u>1.30x</u>

Debt to Capital

LT Debt	\$ 39,024
Minority Interest	\$ -
Unrestricted Net Assets	\$ 286,344
Total	\$ 325,368
 Debt to Capitalization Ratio	 <u>12%</u>
Covenant Requirement	<u>< 65%</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 11,654
Unrestricted Investments	\$ 130,128
Total Cash	\$ 141,782
 Total Operating Expenses (Including Interest)	 \$ 129,469
less: Non Cash Expenses	\$ 12,839
Total Cash Expenses (TTM)	\$ 116,630
 Daily Cash Expenses	 \$ 320
 Days Cash on Hand Ratio	 <u>444 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krulak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 26,171
+ Depreciation	\$ 12,051
+ Amortization	\$ 41
+ Interest Expense	\$ 446
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 38,708
Total Debt Service (MADS)	\$ 4,494
Debt Service Coverage Ratio	8.61x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,035
Minority Interest	\$ -
Unrestricted Net Assets	\$ 308,230
Total	\$ 344,265
Debt to Capitalization Ratio	10%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 10,296
Unrestricted investments	\$ 164,508
Total Cash	\$ 174,804
Total Operating Expenses (Including Interest)	\$ 130,429
less: Non Cash Expenses	\$ 12,092
Total Cash Expenses (TTM)	\$ 118,337
Daily Cash Expenses	\$ 324
Days Cash on Hand Ratio	539 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: Lynn Krutak
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 26,360
+ Depreciation	\$ 12,051
+ Amortization	\$ 41
+ Interest Expense	\$ 446
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 38,897
Total Debt Service (MADS)	\$ 3,061
Debt Service Coverage Ratio	12.71x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,035
Minority Interest	\$ -
Unrestricted Net Assets	\$ 308,419
Total	\$ 344,454
Debt to Capitalization Ratio	10%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 10,296
Unrestricted Investments	\$ 164,508
Total Cash	\$ 174,804
Total Operating Expenses (Including Interest)	\$ 123,998
less: Non Cash Expenses	\$ 12,092
Total Cash Expenses (TTM)	\$ 111,906
Daily Cash Expenses	\$ 307
Days Cash on Hand Ratio	570 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: Lynn Krutak
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Consolidated
Key Operating Indicators
For the Period Ended June 30, 2015

	MONTH OF JUNE			TWELVE MONTHS YEAR TO DATE		
	Actual	Budget	PY Var	Actual	Budget	PY Var
Operating Statistics (excl Long-Term Care)						
Average Daily Census	81	71	14.3%	81	69	17.5%
Occupancy Percent	70.2%	61.1%	14.3%	70.1%	59.6%	17.5%
Patient Days	2,444	2,128	14.3%	29,680	25,232	17.5%
Admissions	739	639	15.6%	9,009	7,646	17.8%
Observation Visits	339	299	30.9%	3,816	3,717	2.7%
Non OB Observation Visits	247	181	36.5%	2,816	2,625	7.3%
Non OB Observation Visits % of Non OB Observation Visits & Acute Admissions	25.1%	22.1%	13.5%	23.8%	25.6%	-6.8%
Non OB Observation % of Occupancy	7.9%	5.4%	46.3%	6.9%	6.5%	6.1%
Adjusted Patient Days	6,357	5,435	17.7%	75,521	66,126	14.2%
Adjusted Admissions	1,934	1,632	18.5%	22,839	20,038	14.5%
Outpatient Visits	20,286	17,953	12.7%	225,145	221,374	3.5%
ED Visits	3,494	2,989	16.6%	41,308	36,299	13.8%
Home Health Episodes	60	129	-53.5%	646	1,543	-58.1%
IP Surgery Cases	114	121	-5.8%	1,468	1,443	1.7%
OP Surgery Cases	476	460	3.5%	5,265	5,655	-6.9%
Revenue By Source						
Medicare	35.1%	39.6%	-3.5%	38.1%	38.6%	-1.4%
Managed Medicare	17.9%	13.3%	4.6%	15.5%	13.3%	2.2%
Medicaid	12.1%	13.9%	-1.8%	12.2%	13.9%	-1.7%
TennCare	0.3%	0.3%	0.0%	0.4%	0.3%	0.3%
Blue Cross	16.8%	16.3%	0.5%	17.1%	16.3%	0.8%
United - River Valley	2.4%	1.7%	0.7%	1.7%	1.7%	0.0%
Managed Care / Commercial	6.7%	1.3%	5.4%	5.6%	5.4%	0.2%
Charity / Self Pay	6.0%	7.8%	-1.9%	7.5%	7.8%	-0.3%
Other Patient Revenue	1.8%	1.7%	0.0%	1.9%	1.7%	0.2%
Total Gross Patient Revenue	100.0%	100.0%		100.0%	100.0%	
IP Revenue per Patient Day	\$9,395	\$10,453	-4.4%	\$9,368	\$10,495	-10.7%
OP Revenue per Outpatient Visit	\$1,948	\$1,921	1.4%	\$1,875	\$1,969	-3.3%
Operating Revenue per Adjusted Patient Day	\$2,346	\$2,033	15.5%	\$2,033	\$2,095	-0.1%
Operating Expense per Adjusted Patient Day	\$1,774	\$1,896	5.9%	\$1,724	\$1,893	8.4%
Operating Revenue per Adjusted Admission	\$5,368	\$6,769	14.7%	\$6,692	\$6,716	-0.4%
Operating Expense per Adjusted Admission	\$2,871	\$8,281	6.8%	\$5,676	\$6,212	8.6%
Net Revenue % of Gross Revenue	21.8%	19.1%	14.1%	21.2%	20.5%	3.7%
Net Revenue per Adjusted Admission	\$7,221	\$6,666	8.3%	\$6,544	\$6,609	-1.0%
Labor Management (excl Long-Term Care)						
Employed Full Time Equivalents	902	815	-10.7%	824	805	-2.3%
Contract Full Time Equivalents	14	2	-453.7%	10	4	-133.1%
Total Full Time Equivalents	916	818	-12.0%	834	810	-3.0%
FTEs per Adjusted Occupied Bed (incl Cont Lbr)	4.30	4.51	4.8%	4.03	4.47	9.8%
Man Hours per Adjusted Admission (incl Cont Lbr)	81.0	85.6	5.9%	75.6	84.0	10.0%
Average Hourly Rate (excl Cont Lbr)	\$21.70	\$21.68	2.6%	\$22.01	\$21.56	-2.1%
Salary Expense per FTE (excl Cont Lbr)	\$43,894	\$45,084	2.6%	\$45,760	\$44,851	-2.1%
Labor Exp (excl Phys) per Adjusted Admission	\$2,481	\$2,548	2.6%	\$2,245	\$2,403	6.8%
Labor Exp % of Net Revenue	37.4%	42.5%	12.0%	39.7%	42.7%	7.2%
Patient Resource Management						
Overall Medicare Average Length of Stay	3.60	3.66	1.6%	3.58	3.62	1.1%
Acute Medicare Average Length of Stay	3.31	3.33	0.7%	3.29	3.30	0.2%
Acute Medicare Average Length of Stay - Acuity Adjusted	3.60	3.65	1.5%	3.58	3.62	1.1%
Acute Overall Average Length of Stay	2.49	2.49	12.7%	2.57	2.83	9.0%
Acute Overall Average Length of Stay - Acuity Adjusted	3.31	3.33	0.7%	3.29	3.30	0.2%
Acute Overall Average Length of Stay - Acuity Adjusted	2.42	2.80	13.5%	2.49	2.77	10.3%
Observation Average Length of Stay	1.11	1.04	-7.2%	1.03	1.04	1.1%
Overall Medicare Case Mix Index	1.44	1.23	-12.8%	1.38	1.28	-8.6%
Overall Case Mix Index	1.34	1.11	-20.4%	1.30	1.11	-16.7%
Acute Medicare Case Mix Index	1.44	1.28	-12.8%	1.39	1.28	-8.6%
Acute Overall Case Mix Index	1.37	1.19	-14.8%	1.32	1.19	-11.2%
Supply Expense % of Net Revenue	14.0%	15.7%	10.9%	14.3%	15.6%	4.9%
Supply Expense per Adjusted Admission	\$1,009	\$1,046	3.5%	\$971	\$1,031	5.8%

**Johnston Memorial Consolidated
Statement of Revenue and Expense
For the Period Ended June 30, 2015**

	MONTH OF JUNE			TWELVE MONTHS YEAR TO DATE				
	Actual	Budget	Bud Var	Actual	Budget	Bud Var	Prior Yr	PY Var
Revenue, Gains and Support								
Patient Service Revenue, Net of Contractual Allowances and Discounts	14,934,725	12,984,304	15.0%	170,877,822	157,853,038	8.1%	143,069,171	19.3%
Provision for Bad Debt	(967,447)	(2,105,455)	54.1%	(20,575,519)	(25,430,908)	19.1%	(17,002,826)	-21.0%
Net Patient Service Revenue	13,967,277	10,878,849	28.4%	150,102,303	132,422,130	13.4%	126,066,344	-19.1%
Premium Revenue	0	0	0.0%	0	0	0.0%	0	0.0%
Net Investment Gain	1,630,152	398,987	308.6%	3,168,693	1,922,546	64.8%	9,606,730	-67.0%
Net Derivative Gain	0	0	0.0%	0	0	0.0%	0	0.0%
Other Revenue, Gains and Support	937,577	161,197	481.6%	2,800,711	1,904,928	47.0%	5,590,722	-46.9%
Total Revenue, Gains and Support	16,535,006	11,439,034	-44.5%	156,071,707	136,249,601	-14.5%	141,263,797	-10.5%
Expense								
Salaries and Wages	3,821,667	3,020,489	-26.5%	36,287,219	36,114,546	-6.0%	35,921,566	-6.6%
Provider Salaries	584,227	622,860	4.6%	9,772,833	10,109,225	3.3%	14,467,792	32.5%
Contract Labor	140,203	43,990	-218.7%	1,442,268	790,664	-82.4%	662,573	-111.8%
Employee Benefits	1,236,682	940,901	-31.4%	10,566,163	9,591,700	-10.4%	8,892,752	-19.0%
Fees	1,843,922	1,481,240	-24.5%	20,794,956	18,136,262	-14.7%	19,593,842	-6.1%
Supplies	1,951,820	1,706,428	-14.4%	22,269,900	20,653,207	-7.8%	19,567,473	-13.8%
Utilities	145,288	175,786	17.3%	2,086,909	2,075,706	-0.5%	1,956,593	-6.6%
Medical Costs	0	0	0.0%	0	0	0.0%	0	0.0%
Other Expense	1,014,329	856,322	-18.5%	10,358,305	10,559,317	1.9%	8,296,879	-24.8%
Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0	0.0%	0	0.0%
Depreciation	1,016,073	1,143,186	11.1%	12,050,632	13,177,926	8.6%	12,797,707	5.8%
Amortization	3,418	3,418	0.0%	41,020	41,020	0.0%	41,020	0.0%
Interest & Taxes	33,312	36,076	7.7%	446,090	482,914	7.6%	577,528	22.8%
Consolidation Allocation	115,905	220,291	47.7%	2,627,662	2,750,966	4.5%	6,480,950	59.5%
Total Expenses	11,916,248	10,251,018	-16.2%	130,764,156	124,483,676	-5.0%	129,278,706	-1.1%
Excess of Revenue, Gains and Support over Expenses and Losses	4,618,758	1,188,015	-288.8%	25,307,551	11,765,925	-115.1%	11,985,090	-111.2%

Johnston Memorial Consolidated
Comparative Balance Sheet

	June 30 2015	May 31 2015	Month Activity	June 30 2014	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	10,286,333	9,701,014	585,319	11,653,780	(1,357,448)
Current Portion AWUIL	0	0	0	0	(0)
Accounts Receivable (Net)	22,263,497	21,319,582	943,915	21,666,389	587,128
Other Receivables	2,161,934	1,603,808	558,126	2,704,886	(542,952)
Due From Affiliates	131,489	2,826,927	(2,645,438)	391,988	(210,509)
Due From Third Party Payers	1,741,384	1,573,280	168,103	1,765,400	(24,017)
Inventories	2,946,517	3,028,826	(82,308)	2,957,365	(10,846)
Prepaid Expense	683,920	574,956	108,965	634,974	48,947
	40,275,074	40,528,392	(353,318)	41,774,772	(1,499,638)
ASSETS WHOSE USE IS LIMITED	0	0	0	0	(0)
OTHER INVESTMENTS	164,507,693	159,338,110	4,569,593	130,127,592	34,380,041
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	259,038,348	259,227,153	(188,805)	257,352,857	1,685,491
Less Allowances for Depreciation	101,420,225	100,474,207	946,018	90,051,439	11,368,726
	157,618,123	158,752,947	(1,134,824)	167,301,358	(9,683,235)
OTHER ASSETS	0	0	0	0	0
Pledges Receivable	0	0	0	0	0
Long Term Compensation Investment	199,510	199,510	0	199,510	0
Investments in Unconsolidated Subsidiaries	0	0	0	0	0
Land / Equipment Held for Resale	1,861,941	1,518,216	343,724	1,518,216	343,724
Assets Held for Expansion	89,828	69,828	0	69,828	0
Investments in Subsidiaries	207,711	211,130	(3,418)	248,732	(41,020)
Goodwill	2,338,990	1,998,665	340,306	2,035,268	302,704
Deferred Charges and Other	364,739,821	361,518,134	3,421,687	341,240,009	23,499,812
TOTAL ASSETS	580,807,272	580,807,272	1,849,511	540,349,497	399,575
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	7,093,747	6,315,928	777,819	7,159,836	(66,089)
Accrued Salaries, Benefits, and PTO	0	0	0	0	0
Claims Payable	34,163	35,263	(1,100)	35,014	(851)
Accrued Interest	758,746	2,934,465	(2,175,719)	363,033	365,713
Due to Affiliates	2,261,830	2,261,830	0	2,261,830	0
Due to Third Party Payers	0	0	0	0	0
Call Option Liability	17,564,742	1,498,276	16,066,467	3,042,473	14,522,270
Current Portion of Long Term Debt	33,516,321	16,999,343	16,516,977	18,265,703	15,250,618
OTHER NON-CURRENT LIABILITIES					
Long Term Compensation Payable	18,470,351	34,562,611	(16,092,259)	35,981,126	(17,510,775)
Long Term Debt	0	0	0	0	0
Estimated Fair Value of Interest Rate Swaps	2,651,393	4,515,591	(1,864,208)	2,086,237	565,146
Deferred Income	1,013,939	771,520	242,419	1,125,666	(112,727)
Professional Liability Self-Insurance and Other	22,135,673	39,849,721	(17,714,049)	39,194,029	(17,058,357)
TOTAL LIABILITIES	55,551,994	56,849,065	(1,197,071)	57,459,732	(1,607,739)
NET ASSETS					
Restricted Net Assets	481	481	0	481	0
Unrestricted Net Assets	306,418,731	303,799,973	4,618,758	283,779,796	24,638,936
Noncontrolling Interests in Subsidiaries	688,615	668,615	0	668,615	0
	309,097,827	304,469,069	4,618,758	283,780,277	25,307,551
TOTAL LIABILITIES AND NET ASSETS	364,739,821	361,318,134	3,421,687	341,240,009	23,499,812

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America³ and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>7,800</u>
+ Depreciation	\$ <u>15,377</u>
+ Amortization	\$ <u>41</u>
+ Interest Expense	\$ <u>467</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary items	\$ <u>-</u>
EBITDA	\$ <u>20,746</u>
Total Debt Service (MADS)	\$ <u>4,326</u>
Debt Service Coverage Ratio	<u>4.80x</u>
Covenant Requirement	<u>1.30x</u>

Debt to Capital

LT Debt	\$ <u>38,874</u>
Minority Interest	\$ <u>-</u>
Unrestricted Net Assets	\$ <u>271,703</u>
Total	\$ <u>310,577</u>
Debt to Capitalization Ratio	<u>13%</u>
Covenant Requirement	<u>< 65%</u>

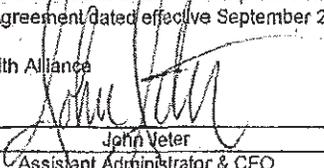
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
Total Operating Expenses (Including Interest)	\$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TMM)	\$ <u>-</u>
Daily Cash Expenses	\$ <u>-</u>
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: John Vetter
Title: Assistant Administrator & CFO

Johnston Memorial Hospital

Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 13,378
+ Depreciation	\$ 11,903
+ Amortization	\$ 41
+ Interest Expense	\$ 552
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 25,874
 Total Debt Service (MADS)	 \$ 4,493

Debt Service Coverage Ratio 5.76x

Covenant Requirement 1.30x

Debt to Capital

LT Debt	\$ 36,884
Minority Interest	\$ -
Unrestricted Net Assets	\$ 286,873
Total	\$ 323,757
 Debt to Capitalization Ratio	 <u>11%</u>
Covenant Requirement	<u>< 65%</u>

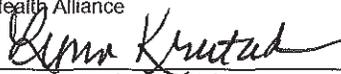
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
 Total Operating Expenses (Including Interest)	 \$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
 Daily Cash Expenses	 \$ -
 Days Cash on Hand Ratio	 <u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 1,856
+ Depreciation	\$ 15,127
+ Amortization	\$ 42
+ Interest Expense	\$ 544
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 17,569
Total Debt Service (MADS)	\$ 4,324
Debt Service Coverage Ratio	4.06x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 38,751
Minority Interest	\$ -
Unrestricted Net Assets	\$ 272,311
Total	\$ 311,062
Debt to Capitalization Ratio	12%
Covenant Requirement	< 65%

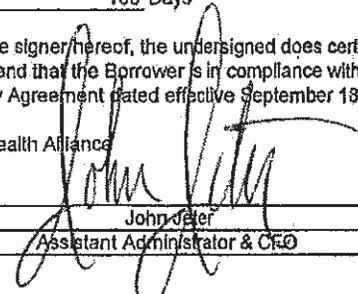
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 5,082
Unrestricted Investments	\$ 128,414
Total Cash	\$ 133,496
Total Operating Expenses (Including Interest)	\$ 132,166
less: Non Cash Expenses	\$ 15,169
Total Cash Expenses (TTM)	\$ 116,997
Daily Cash Expenses	\$ 321
Days Cash on Hand Ratio	416 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
 Print Name: John Oster
 Title: Assistant Administrator & CEO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Johnston Memorial Hospital dated September 18, 2012, we hereby represent and warrant as follows:

Status as of: 12/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 18,352
+ Depreciation	\$ 11,228
+ Amortization	\$ 41
+ Interest Expense	\$ 518
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 30,139
Total Debt Service (MADS)	\$ 4,492
Debt Service Coverage Ratio	6.71x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 34,577
Minority Interest	\$ -
Unrestricted Net Assets	\$ 288,761
Total	\$ 323,338
Debt to Capitalization Ratio	11%
Covenant Requirement	< 65%

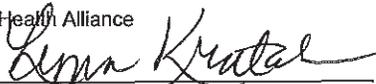
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 16,628
Unrestricted Investments	\$ 138,070
Total Cash	\$ 154,698
Total Operating Expenses (Including Interest)	\$ 124,696
less: Non Cash Expenses	\$ 11,269
Total Cash Expenses (TTM)	\$ 113,427
Daily Cash Expenses	\$ 311
Days Cash on Hand Ratio	498 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 1,521
+ Depreciation	\$ 15,089
+ Amortization	\$ 42
+ Interest Expense	\$ 601
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 17,253
Total Debt Service (MADS)	\$ 4,323
Debt Service Coverage Ratio	3.99x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 39,318
Minority Interest	\$ -
Unrestricted Net Assets	\$ 272,927
Total	\$ 312,245
Debt to Capitalization Ratio	13%
Covenant Requirement	< 65%

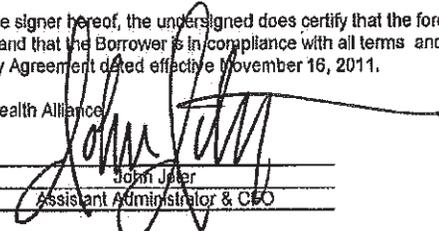
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
 Print Name: John Jeter
 Title: Assistant Administrator & CEO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 18,472
+ Depreciation	\$ 11,003
+ Amortization	\$ 49
+ Interest Expense	\$ 348
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 29,872
 Total Debt Service (MADS)	 \$ 4,492
 Debt Service Coverage Ratio	 6.65x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,269
Minority Interest	\$ -
Unrestricted Net Assets	\$ 298,268
Total	\$ 334,537
 Debt to Capitalization Ratio	 11%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
 Total Operating Expenses (Including Interest)	 \$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
 Daily Cash Expenses	 \$ -
 Days Cash on Hand Ratio	 N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By:

Print Name:

Title:

Lynn Krutak
Lynn Krutak
Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 8,606
+ Depreciation	\$ 12,798
+ Amortization	\$ 41
+ Interest Expense	\$ 578
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 22,023
 Total Debt Service (MADS)	 \$ 4,321
 Debt Service Coverage Ratio	 <u>5.10x</u>
Covenant Requirement	<u>1.30x</u>

Debt to Capital

LT Debt	\$ 39,024
Minority Interest	\$ -
Unrestricted Net Assets	\$ 286,344
Total	\$ 325,368
 Debt to Capitalization Ratio	 <u>12%</u>
Covenant Requirement	<u>< 65%</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 11,654
Unrestricted Investments	\$ 130,128
Total Cash	\$ 141,782
 Total Operating Expenses (Including Interest)	 \$ 129,469
less: Non Cash Expenses	\$ 12,839
Total Cash Expenses (TTM)	\$ 116,630
 Daily Cash Expenses	 \$ 320
 Days Cash on Hand Ratio	 <u>444 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 26,171
+ Depreciation	\$ 12,051
+ Amortization	\$ 41
+ Interest Expense	\$ 446
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 38,708
Total Debt Service (MADS)	\$ 4,494
Debt Service Coverage Ratio	8.61x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,035
Minority Interest	\$ -
Unrestricted Net Assets	\$ 308,230
Total	\$ 344,265
Debt to Capitalization Ratio	10%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 10,296
Unrestricted Investments	\$ 164,508
Total Cash	\$ 174,804
Total Operating Expenses (Including Interest)	\$ 130,429
less: Non Cash Expenses	\$ 12,092
Total Cash Expenses (TTM)	\$ 118,337
Daily Cash Expenses	\$ 324
Days Cash on Hand Ratio	539 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutek
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 26,360
+ Depreciation	\$ 12,051
+ Amortization	\$ 41
+ Interest Expense	\$ 446
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 38,897
Total Debt Service (MADS)	\$ 3,061
Debt Service Coverage Ratio	12.71x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,035
Minority Interest	\$ -
Unrestricted Net Assets	\$ 308,419
Total	\$ 344,454
Debt to Capitalization Ratio	10%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 10,296
Unrestricted Investments	\$ 164,508
Total Cash	\$ 174,804
Total Operating Expenses (Including Interest)	\$ 123,998
less: Non Cash Expenses	\$ 12,092
Total Cash Expenses (TTM)	\$ 111,906
Daily Cash Expenses	\$ 307
Days Cash on Hand Ratio	570 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Consolidated
Key Operating Indicators
For the Period Ended June 30, 2015

	MONTH OF JUNE			TWELVE MONTHS YEAR TO DATE		
	Actual	Budget	PY Var	Actual	Budget	PY Var
Operating Statistics (excl. Long-Term Care)						
Average Daily Census	81	71	14.3%	81	89	17.5%
Occupancy Percent	70.2%	61.4%	14.3%	70.1%	59.8%	26.1%
Patient Days	2,444	2,128	14.3%	29,660	25,232	26.1%
Admissions	739	649	13.9%	9,009	7,646	26.7%
Observation Visits	339	299	13.4%	3,717	3,130	27.6%
Non OB Observation Visits	247	201	22.9%	2,816	2,893	-7.6%
Non OB Observation Visits % of Non OB Observation Visits & Acute Admissions	25.1%	23.6%	5.9%	23.8%	25.6%	-19.6%
Non OB Observation % of Occupancy	7.9%	46.3%	-3.5%	6.9%	6.1%	-34.4%
Adjusted Patient Days	6,337	5,435	17.7%	75,521	66,128	7.8%
Adjusted Admissions	1,934	1,632	18.5%	22,939	20,039	8.4%
ED Visits	20,296	17,993	12.7%	229,145	221,374	8.2%
Home Health Episodes	3,484	2,989	16.8%	41,308	36,239	13.6%
IP Surgery Cases	60	129	-53.5%	1,543	811	-20.3%
OP Surgery Cases	114	121	-5.8%	1,443	1,296	13.3%
	476	460	3.5%	5,265	5,560	-5.3%
Revenue, By Source						
Medicare	36.1%	36.7%	-0.6%	36.1%	36.6%	-1.3%
Managed Medicare	17.9%	12.8%	4.6%	15.5%	13.3%	2.2%
Medicaid	12.1%	13.4%	-1.3%	12.2%	13.9%	-1.4%
TenCare	0.3%	0.4%	-0.1%	0.4%	0.3%	0.3%
Blue Cross	16.8%	16.3%	0.5%	17.1%	16.3%	0.5%
United - River Valley	2.4%	1.7%	0.7%	1.7%	0.0%	1.7%
Managed Care / Commercial	6.0%	5.4%	0.6%	5.6%	5.4%	0.2%
Charity / Self Pay	6.0%	7.8%	-1.9%	7.5%	7.8%	-0.3%
Other Patient Revenue	1.8%	2.1%	-0.3%	1.8%	1.7%	0.2%
Total Gross Patient Revenue	100.0%	100.0%		100.0%	100.0%	
IP Revenue per Patient Day	\$9,895	\$10,453	-4.4%	\$9,868	\$10,485	-10.7%
OP Revenue per Outpatient Visit	\$1,948	\$1,921	1.4%	\$1,875	\$1,969	-3.3%
Operating Revenue per Adjusted Patient Day	\$2,348	\$2,033	15.5%	\$2,053	\$2,095	-0.1%
Operating Expense per Adjusted Patient Day	\$1,774	\$1,886	5.9%	\$1,724	\$1,863	8.4%
Operating Revenue per Adjusted Admission	\$7,766	\$6,769	14.7%	\$6,922	\$6,716	-0.4%
Operating Expense per Adjusted Admission	\$5,868	\$6,281	6.6%	\$5,878	\$6,212	8.6%
Net Revenue % of Gross Revenue	21.8%	19.1%	14.1%	21.2%	20.5%	3.7%
Net Revenue per Adjusted Admission	\$7,221	\$6,666	8.3%	\$6,544	\$6,909	-1.0%
Labor Management (excl. Long-Term Care)						
Employed Full Time Equivalents	902	815	-10.7%	824	805	-2.3%
Contract Full Time Equivalents	14	2	-453.7%	10	4	-133.1%
Total Full Time Equivalents	916	818	-12.0%	834	810	-3.0%
FTEs per Adjusted Occupied Bed (incl. Cont. Lbr)	4.30	4.51	4.8%	4.03	4.47	9.8%
Man Hours per Adjusted Admission (incl. Cont. Lbr)	81.0	85.6	5.5%	76.6	84.0	10.0%
Average Hourly Rate (excl. Cont. Lbr)	\$21.10	\$21.68	2.6%	\$21.66	\$22.01	-2.1%
Salary Expense per FTE (excl. Cont. Lbr)	\$43,854	\$45,094	2.6%	\$45,760	\$44,851	-2.1%
Labor Exp (excl. Phys) per Adjusted Admission	\$2,451	\$2,548	2.6%	\$2,245	\$2,408	6.8%
Labor Exp % of Net Revenue	37.4%	42.5%	12.0%	39.7%	42.7%	7.2%
Patient Resource Management						
Overall Medicare Average Length of Stay	3.60	3.66	1.6%	3.58	3.62	1.1%
Overall Average Length of Stay	3.31	3.33	0.7%	3.29	3.32	0.2%
Acute Medicare Average Length of Stay	3.60	3.65	1.5%	3.58	3.62	1.1%
Acute Medicare Average Length of Stay - Acuity Adjusted	2.49	2.85	12.7%	2.57	2.83	9.0%
Acute Overall Average Length of Stay	3.31	3.33	0.7%	3.29	3.30	0.2%
Acute Overall Average Length of Stay - Acuity Adjusted	2.42	2.80	13.5%	2.49	2.77	10.3%
Observation Average Length of Stay	1.11	1.04	-7.2%	1.04	1.04	1.1%
Overall Medicare Case Mix Index	1.44	1.28	12.6%	1.39	1.28	6.6%
Overall Case Mix Index	1.34	1.11	20.9%	1.30	1.11	16.7%
Overall Medicare Case Mix Index	1.44	1.28	12.6%	1.39	1.28	6.6%
Acute Medicare Case Mix Index	1.37	1.19	14.8%	1.32	1.19	11.2%
Acute Overall Case Mix Index	1.40%	1.57%	10.9%	1.48%	1.56%	4.4%
Supply Expense % of Net Revenue	\$1,009	\$1,046	3.5%	\$971	\$1,031	5.6%
Supply Expense per Adjusted Admission						

**Johnston Memorial Consolidated
Statement of Revenue and Expense
For the Period Ended June 30, 2015**

	MONTH OF JUNE			TWELVE MONTHS YEAR TO DATE			PY Var
	Actual	Budget	Bud Var	Actual	Budget	Bud Var	
Revenue, Gains, and Support							
Patient Service Revenue, Net of Contractual Allowances and Discounts	14,984,725	12,984,304	15.0%	170,677,822	157,853,038	8.1%	143,069,171
Provision for Bad Debt	(987,447)	(2,105,455)	54.1%	(20,575,519)	(25,430,908)	19.1%	(17,002,826)
Net Patient Service Revenue	13,997,277	10,878,849	30.8%	150,102,303	132,422,130	13.4%	126,066,344
Premium Revenue	0	0	0.0%	0	0	0.0%	0
Net Investment Gain	1,630,152	398,987	308.6%	3,168,693	1,922,546	64.8%	9,606,730
Net Derivative Gain	0	0	0.0%	0	0	0.0%	0
Other Revenue, Gains and Support	937,577	161,197	481.6%	2,800,711	1,904,926	47.0%	5,690,722
Total Revenue, Gains and Support	16,535,006	11,439,034	-44.5%	156,071,707	136,249,601	-14.5%	141,263,797
Expense							
Salaries and Wages	3,821,667	3,020,489	-26.5%	38,287,219	36,114,546	-6.0%	35,921,566
Provider Salaries	584,227	622,890	4.6%	9,772,833	10,108,225	3.3%	14,467,792
Contract Labor	140,203	43,990	-218.7%	1,442,268	790,864	-82.4%	882,573
Employee Benefits	1,236,682	940,901	-31.4%	10,586,163	9,591,700	-10.4%	8,892,782
Fees	1,843,922	1,481,240	-24.5%	20,784,956	18,136,282	-14.7%	19,593,842
Supplies	1,951,820	1,706,429	-14.4%	22,269,900	20,653,207	-7.8%	19,567,473
Utilities	145,288	175,766	17.3%	2,085,909	2,075,706	-0.5%	1,856,593
Medical Costs	0	0	0.0%	0	0	0.0%	0
Other Expense	1,014,329	858,322	-18.5%	10,358,305	10,559,317	1.9%	8,296,879
Loss on Extinguishment of LTD / Derivatives	0	0	0.0%	0	0	0.0%	0
Depreciation	1,016,073	1,143,186	11.1%	12,050,632	13,177,926	8.6%	12,797,707
Amortization	3,418	3,418	0.0%	41,020	41,020	0.0%	41,020
Interest & Taxes	33,312	36,076	7.7%	446,090	482,914	7.8%	577,629
Consolidation Allocation	115,305	220,291	47.7%	2,627,862	2,750,966	4.5%	6,480,950
Total Expenses	11,916,248	10,251,018	-16.2%	130,764,156	124,483,676	-5.0%	129,278,706
Excess of Revenue, Gains and Support over Expenses and Losses	4,618,758	1,188,015	-288.8%	25,307,551	11,765,925	-115.1%	11,985,090

**Johnston Memorial Consolidated
Comparative Balance Sheet**

	June 30 2015	May 31 2015	Month Activity	June 30 2014	YTD Activity
ASSETS					
CURRENT ASSETS					
Cash and Cash Equivalents	10,286,333	9,701,014	585,319	11,653,780	(1,357,448)
Current Portion AWWIL	0	0	0	0	(0)
Accounts Receivable (Net)	22,263,487	21,319,552	943,915	21,666,389	597,128
Other Receivables	2,181,934	1,803,308	558,126	2,704,886	(542,952)
Due From Affiliates	181,459	2,826,927	(2,645,438)	391,988	(210,509)
Due From Third Party Payers	1,741,384	1,573,280	188,103	1,765,400	(24,017)
Inventories	2,948,517	3,028,828	(82,308)	2,857,955	(10,848)
Prepaid Expense	583,920	574,956	108,965	634,974	48,947
	40,275,074	40,628,392	(353,318)	41,774,772	(1,499,698)
ASSETS WHOSE USE IS LIMITED	0	0	0	0	(0)
OTHER INVESTMENTS	164,507,693	159,938,110	4,569,523	130,127,592	34,380,041
PROPERTY, PLANT AND EQUIPMENT					
Land, Buildings and Equipment	259,038,348	259,227,153	(188,805)	257,352,857	1,685,491
Less Allowances for Depreciation	101,420,225	100,474,207	946,018	90,051,499	11,368,726
	157,618,123	158,752,947	(1,134,324)	167,301,358	(9,683,235)
OTHER ASSETS	0	0	0	0	0
Pledges Receivable	0	0	0	0	0
Long Term Compensation Investment	0	0	0	0	0
Investments in Unconsolidated Subsidiaries	199,510	199,510	0	199,510	0
Land / Equipment Held for Resale	0	0	0	0	0
Assets Held for Expansion	1,861,941	1,518,216	343,724	1,518,216	343,724
Investments in Subsidiaries	69,828	69,828	0	69,828	0
Goodwill	207,711	211,130	(3,418)	248,732	(41,020)
Deferred Charges and Other	2,338,990	1,998,685	340,306	2,035,286	302,704
	364,739,821	351,318,134	3,421,687	341,240,009	23,499,812
LIABILITIES AND NET ASSETS					
CURRENT LIABILITIES					
Accounts Payable and Accrued Expense	5,803,072	3,953,561	1,849,511	5,403,487	399,575
Accrued Salaries, Benefits, and PTO	7,093,747	6,315,928	777,819	7,159,836	(66,089)
Claims Payable	0	0	0	0	0
Accrued Interest	34,163	35,263	(1,100)	35,014	(851)
Due to Affiliates	758,746	2,834,465	(2,175,719)	363,033	395,713
Due to Third Party Payers	2,261,890	2,261,850	0	2,251,950	0
Call Option Liability	0	0	0	0	0
Current Portion of Long Term Debt	17,564,742	1,498,276	16,066,467	3,042,473	14,522,270
	33,516,321	18,999,343	16,516,977	18,265,703	15,250,618
OTHER NON CURRENT LIABILITIES					
Long Term Compensation Payable	0	0	0	0	0
Long Term Debt	18,470,351	34,562,611	(16,092,259)	35,991,126	(17,510,775)
Estimated Fair Value of Interest Rate Swaps	0	0	0	0	0
Deferred Income	2,651,383	4,515,591	(1,864,208)	2,086,237	565,146
Professional Liability Self-Insurance and Other	1,013,939	771,520	242,419	1,126,666	(112,727)
	22,135,673	39,849,721	(17,714,049)	39,194,029	(17,058,357)
TOTAL LIABILITIES	55,651,994	58,849,065	(1,197,071)	57,459,732	(1,807,739)
NET ASSETS					
Restricted Net Assets	481	481	0	481	0
Unrestricted Net Assets	308,418,731	303,799,973	4,618,758	283,779,796	24,638,996
Noncontrolling Interests in Subsidiaries	668,615	668,615	0	0	668,615
	309,087,827	304,469,069	4,618,758	283,780,277	25,307,551
TOTAL LIABILITIES AND NET ASSETS	364,739,821	351,318,134	3,421,687	341,240,009	23,499,812

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 13,378
+ Depreciation	\$ 11,903
+ Amortization	\$ 41
+ Interest Expense	\$ 552
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 25,874
 Total Debt Service (MADS)	 \$ 4,493
 Debt Service Coverage Ratio	 5.76x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 36,884
Minority Interest	\$ -
Unrestricted Net Assets	\$ 286,873
Total	\$ 323,757
 Debt to Capitalization Ratio	 11%
Covenant Requirement	< 65%

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
 Total Operating Expenses (Including Interest)	 \$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
 Daily Cash Expenses	 \$ -
 Days Cash on Hand Ratio	 N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 9/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 25,817
+ Depreciation	\$ 11,972
+ Amortization	\$ 41
+ Interest Expense	\$ 432
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 38,262
Total Debt Service (MADS)	\$ 3,143
Debt Service Coverage Ratio	<u>12.17x</u>
Covenant Requirement	<u>1.30x</u>

Debt to Capital

LT Debt	\$ 17,300
Minority Interest	\$ -
Unrestricted Net Assots	\$ 308,520
Total	\$ 325,820
Debt to Capitalization Ratio	<u>5%</u>
Covenant Requirement	<u>< 65%</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 18, 2012.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 1,856
+ Depreciation	\$ 15,127
+ Amortization	\$ 42
+ Interest Expense	\$ 544
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 17,569
Total Debt Service (MADS)	\$ 4,324
Debt Service Coverage Ratio	4.06x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 38,751
Minority Interest	\$ -
Unrestricted Net Assets	\$ 272,311
Total	\$ 311,062
Debt to Capitalization Ratio	12%
Covenant Requirement	< 65%

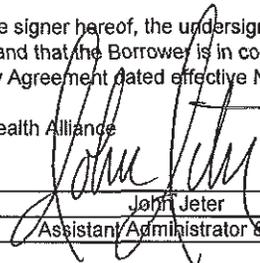
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 5,082
Unrestricted Investments	\$ 128,414
Total Cash	\$ 133,496
Total Operating Expenses (Including Interest)	\$ 132,166
less: Non Cash Expenses	\$ 15,169
Total Cash Expenses (TTM)	\$ 116,997
Daily Cash Expenses	\$ 321
Days Cash on Hand Ratio	416 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
 Print Name: John Jeter
 Title: Assistant Administrator & CFO

Johnston Memorial Hospital
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Johnston Memorial Hospital dated November 16, 2011, we hereby represent and warrant as follows:

Status as of: 12/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 18,352
+ Depreciation	\$ 11,228
+ Amortization	\$ 41
+ Interest Expense	\$ 518
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 30,139
Total Debt Service (MADS)	\$ 4,492
Debt Service Coverage Ratio	6.71x
Covenant Requirement	1.30x

Debt to Capital

LT Debt	\$ 34,577
Minority Interest	\$ -
Unrestricted Net Assets	\$ 288,761
Total	\$ 323,338
Debt to Capitalization Ratio	11%
Covenant Requirement	< 65%

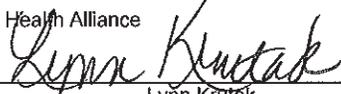
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 16,628
Unrestricted Investments	\$ 138,070
Total Cash	\$ 154,698
Total Operating Expenses (Including Interest)	\$ 124,696
less: Non Cash Expenses	\$ 11,269
Total Cash Expenses (TTM)	\$ 113,427
Daily Cash Expenses	\$ 311
Days Cash on Hand Ratio	498 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective November 16, 2011.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ (7,162)
+ Depreciation	\$ 60,678
+ Amortization	\$ 1,859
+ Interest Expense	\$ 42,191
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 102,188
Total Debt Service (MADS)	\$ 67,267
Debt Service Coverage Ratio	<u>1.52x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 23,297
+ Depreciation	\$ 48,742
+ Amortization	\$ 1,149
+ Interest Expense	\$ 43,382
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 121,192
Total Debt Service (MADS)	\$ 67,246
Debt Service Coverage Ratio	1.80x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 15,340
+ Depreciation	\$ 52,544
+ Amortization	\$ 1,691
+ Interest Expense	\$ 42,734
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 116,931
Total Debt Service (MADS)	\$ 67,257
Debt Service Coverage Ratio	1.74x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 27,419
Unrestricted Investments	\$ 395,346
Total Cash	\$ 422,765
Total Operating Expenses (Including Interest)	\$ 825,612
less: Non Cash Expenses	\$ 54,235
Total Cash Expenses (TTM)	\$ 771,377
Daily Cash Expenses	\$ 2,113
Days Cash on Hand Ratio	200 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 33,771</u>
+ Depreciation	<u>\$ 51,308</u>
+ Amortization	<u>\$ 1,488</u>
+ Interest Expense	<u>\$ 41,598</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary items	<u>\$ -</u>
EBITDA	<u>\$ 128,165</u>
Total Debt Service (MADS)	<u>\$ 67,254</u>
Debt Service Coverage Ratio	<u>1.91x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	<u>\$ 47,024</u>
Unrestricted Investments	<u>\$ 407,932</u>
Total Cash	<u>\$ 454,956</u>
Total Operating Expenses (Including Interest)	<u>\$ 829,866</u>
less: Non Cash Expenses	<u>\$ 52,796</u>
Total Cash Expenses (TTM)	<u>\$ 777,070</u>
Daily Cash Expenses	<u>\$ 2,129</u>
Days Cash on Hand Ratio	<u>214 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 62,408
+ Depreciation	\$ 59,811
+ Amortization	\$ 2,192
+ Interest Expense	\$ 41,609
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 135,723
Total Debt Service (MADS)	\$ 67,286
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

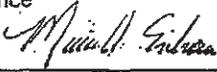
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 37,352
+ Depreciation	\$ 51,344
+ Amortization	\$ 1,539
+ Interest Expense	\$ 42,901
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 133,136
Total Debt Service (MADS)	\$ 67,252
Debt Service Coverage Ratio	1.98x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 13,491
+ Depreciation	\$ 60,683
+ Amortization	\$ 2,028
+ Interest Expense	\$ 41,619
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 122,442
Total Debt Service (MADS)	\$ 67,281
Debt Service Coverage Ratio	1.82x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 8,888
Unrestricted Investments	\$ 388,207
Total Cash	\$ 397,095
Total Operating Expenses (Including Interest)	\$ 821,779
less: Non Cash Expenses	\$ 62,711
Total Cash Expenses (TTM)	\$ 759,068
Daily Cash Expenses	\$ 2,079.64
Days Cash on Hand Ratio	191 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between Bank of America and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>50,906</u>
+ Depreciation	\$ <u>49,984</u>
+ Amortization	\$ <u>1,540</u>
+ Interest Expense	\$ <u>42,765</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary items	\$ <u>-</u>
EBITDA	\$ <u>145,195</u>
Total Debt Service (MADS)	\$ <u>67,240</u>
Debt Service Coverage Ratio	<u>2.16x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>38,810</u>
Unrestricted Investments	\$ <u>387,586</u>
Total Cash	\$ <u>426,396</u>
Total Operating Expenses (Including Interest)	\$ <u>820,364</u>
less: Non Cash Expenses	\$ <u>51,524</u>
Total Cash Expenses (TTM)	\$ <u>768,840</u>
Daily Cash Expenses	\$ <u>2,106</u>
Days Cash on Hand Ratio	<u>202 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between The Bank of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>(7,162)</u>
+ Depreciation	\$ <u>60,678</u>
+ Amortization	\$ <u>1,859</u>
+ Interest Expense	\$ <u>42,191</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary items	\$ <u>4,622</u>
EBITDA	\$ <u>102,188</u>
 Total Debt Service (MADS)	\$ <u>67,267</u>
 Debt Service Coverage Ratio	<u>1.52x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
 Total Operating Expenses (Including Interest)	\$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TTM)	\$ <u>-</u>
 Daily Cash Expenses	\$ <u>-</u>
 Days Cash on Hand Ratio	<u>N/A</u> Days
Covenant Requirement	<u>100</u> Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By:



Print Name: Marvln Eichorn

Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between The Bank Of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 23,297
+ Depreciation	\$ 48,742
+ Amortization	\$ 1,149
+ Interest Expense	\$ 43,382
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 121,192
Total Debt Service (MADS)	\$ 67,246
Debt Service Coverage Ratio	1.80x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between The Bank of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 15,340
+ Depreciation	\$ 52,544
+ Amortization	\$ 1,691
+ Interest Expense	\$ 42,734
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ 4,622
EBITDA	\$ 116,931
Total Debt Service (MADS)	\$ 67,257
Debt Service Coverage Ratio	1.74x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 27,419
Unrestricted Investments	\$ 395,346
Total Cash	\$ 422,765
Total Operating Expenses (Including Interest)	\$ 825,612
less: Non Cash Expenses	\$ 54,235
Total Cash Expenses (TTM)	\$ 771,377
Daily Cash Expenses	\$ 2,113
Days Cash on Hand Ratio	200 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between The Bank Of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 33,771
+ Depreciation	\$ 51,308
+ Amortization	\$ 1,488
+ Interest Expense	\$ 41,598
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 128,165
Total Debt Service (MADS)	\$ 67,254
Debt Service Coverage Ratio	1.91x
Covenant Requirement	1.30x

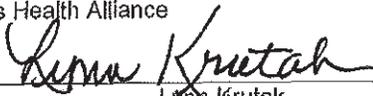
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 47,024
Unrestricted Investments	\$ 407,932
Total Cash	\$ 454,956
Total Operating Expenses (Including Interest)	\$ 829,866
less: Non Cash Expenses	\$ 52,796
Total Cash Expenses (TTM)	\$ 777,070
Daily Cash Expenses	\$ 2,129
Days Cash on Hand Ratio	214 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between The Bank Of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	\$ 62,408
+ Depreciation	\$ 59,811
+ Amortization	\$ 2,192
+ Interest Expense	\$ 41,609
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 135,723
Total Debt Service (MADS)	\$ 67,286
Debt Service Coverage Ratio	2.02x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective June 25, 2013.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between The Bank Of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 37,352
+ Depreciation	\$ 51,344
+ Amortization	\$ 1,539
+ Interest Expense	\$ 42,901
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 133,136
Total Debt Service (MADS)	\$ 67,252
Debt Service Coverage Ratio	1.98x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: Lynn Krutak
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between The Bank of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 13,491
+ Depreciation	\$ 60,683
+ Amortization	\$ 2,028
+ Interest Expense	\$ 41,619
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 122,442
Total Debt Service (MADS)	\$ 67,281
Debt Service Coverage Ratio	1.82x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 8,888
Unrestricted Investments	\$ 388,207
Total Cash	\$ 397,095
Total Operating Expenses (Including Interest)	\$ 821,779
less: Non Cash Expenses	\$ 62,711
Total Cash Expenses (TTM)	\$ 759,068
Daily Cash Expenses	\$ 2,079.64
Days Cash on Hand Ratio	191 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective June 25, 2013.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between The Bank Of New York and Mountain States Health Alliance dated June 25, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,906
+ Depreciation	\$ 49,984
+ Amortization	\$ 1,540
+ Interest Expense	\$ 42,765
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 145,195
Total Debt Service (MADS)	\$ 67,240
Debt Service Coverage Ratio	2.16x
Covenant Requirement	1.30x

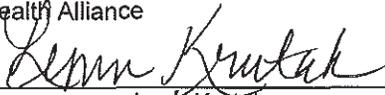
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 38,810
Unrestricted Investments	\$ 387,586
Total Cash	\$ 426,396
Total Operating Expenses (Including Interest)	\$ 820,364
less: Non Cash Expenses	\$ 51,524
Total Cash Expenses (TTM)	\$ 768,840
Daily Cash Expenses	\$ 2,106
Days Cash on Hand Ratio	202 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 49,107
+ Depreciation	\$ 55,307
+ Amortization	\$ 4,903
+ Interest Expense	\$ 43,995
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,827
Total Debt Service (MADS)	\$ 65,782

Debt Service Coverage Ratio 2.23x

Covenant Requirement 1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (including interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A</u> Days
Covenant Requirement	<u>100</u> Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 45,004
+ Depreciation	\$ 56,299
+ Amortization	\$ 2,242
+ Interest Expense	\$ 39,641
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 145,463
Total Debt Service (MADS)	\$ 65,742
Debt Service Coverage Ratio	2.21x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 59,288
+ Depreciation	\$ 56,474
+ Amortization	\$ 2,232
+ Interest Expense	\$ 40,547
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 151,385
Total Debt Service (MADS)	\$ 69,393
Debt Service Coverage Ratio	2.18x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eickhorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ (7,162)
+ Depreciation	\$ 60,678
+ Amortization	\$ 1,859
+ Interest Expense	\$ 42,191
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 102,188
Total Debt Service (MADS)	\$ 67,267
Debt Service Coverage Ratio	<u>1.52x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2011

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	<u>\$ 60,483</u>
+ Depreciation	<u>\$ 61,111</u>
+ Amortization	<u>\$ 2,211</u>
+ Interest Expense	<u>\$ 42,464</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary Items	<u> </u>
EBITDA	<u>\$ 151,293</u>
Total Debt Service (MADS)	<u>\$ 67,625</u>

Debt Service Coverage Ratio	<u>2.24x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand
(Required with June and December Reporting Periods)

Cash	<u>\$ 86,426</u>
Unrestricted Investments	<u>\$ 284,871</u>
Total Cash	<u>\$ 371,297</u>
Total Operating Expenses (Including Interest)	<u>\$ 699,129</u>
less: Non Cash Expenses	<u>\$ 63,322</u>
Total Cash Expenses (TTM)	<u>\$ 636,807</u>
Daily Cash Expenses	<u>\$ 1,742</u>
Days Cash on Hand Ratio	<u>213 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance
By: 
Print Name: Marvin Elchorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>41,119</u>
+ Depreciation	\$ <u>52,865</u>
+ Amortization	\$ <u>2,233</u>
+ Interest Expense	\$ <u>42,009</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	\$ <u>-</u>
EBITDA	\$ <u>146,438</u>
Total Debt Service (MADS)	\$ <u>65,754</u>
Debt Service Coverage Ratio	<u>2.23x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>38,364</u>
Unrestricted Investments	\$ <u>329,369</u>
Total Cash	\$ <u>367,733</u>
Total Operating Expenses (Including Interest)	\$ <u>792,215</u>
less: Non Cash Expenses	\$ <u>55,098</u>
Total Cash Expenses (TTM)	\$ <u>737,117</u>
Daily Cash Expenses	\$ <u>2,019</u>
Days Cash on Hand Ratio	<u>182 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 68,859
+ Depreciation	\$ 58,286
+ Amortization	\$ 2,213
+ Interest Expense	\$ 41,226
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 151,307
Total Debt Service (MADS)	\$ 69,360
Debt Service Coverage Ratio	2.18x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 49,266
Unrestricted Investments	\$ 351,725
Total Cash	\$ 400,991
Total Operating Expenses (including Interest)	\$ 800,349
less: Non Cash Expenses	\$ 60,499
Total Cash Expenses (TTM)	\$ 739,850
Daily Cash Expenses	\$ 2,027
Days Cash on Hand Ratio	198 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 42,447
+ Depreciation	\$ 47,707
+ Amortization	\$ 10,205
+ Interest Expense	\$ 39,725
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 142,532
Total Debt Service (MADS)	\$ 77,187
Debt Service Coverage Ratio	1.85x
Covenant Requirement	1.30x

Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,451
+ Depreciation	\$ 57,953
+ Amortization	\$ 2,233
+ Interest Expense	\$ 39,882
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,901
Total Debt Service (MADS)	\$ 65,667
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,630
+ Depreciation	\$ 56,521
+ Amortization	\$ 2,298
+ Interest Expense	\$ 40,934
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ (2,653)
EBITDA	\$ 148,107
Total Debt Service (MADS)	\$ 69,270
Debt Service Coverage Ratio	<u>2.14x</u>
Covenant Requirement	<u>1.30x</u>

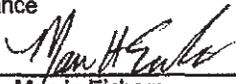
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 62,408
+ Depreciation	\$ 59,811
+ Amortization	\$ 2,192
+ Interest Expense	\$ 41,609
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 135,723
Total Debt Service (MADS)	\$ 67,286
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

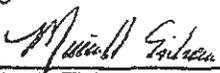
Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 43,001
+ Depreciation	\$ 51,625
+ Amortization	\$ 7,538
+ Interest Expense	\$ 42,968
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 140,875
Total Debt Service (MADS)	\$ 69,886
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

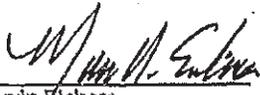
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 167,099
Unrestricted Investments	\$ 183,585
Total Cash	\$ 350,684
Total Operating Expenses (Including Interest)	\$ 686,573
less: Non Cash Expenses	\$ 59,163
Total Cash Expenses (TTM)	\$ 627,410
Daily Cash Expenses	\$ 1,719
Days Cash on Hand Ratio	<u>204 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 39,641
+ Depreciation	\$ 57,427
+ Amortization	\$ 2,268
+ Interest Expense	\$ 39,479
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,118
Total Debt Service (MADS)	\$ 65,751
Debt Service Coverage Ratio	<u>2.22x</u>
Covenant Requirement	<u>1.30x</u>

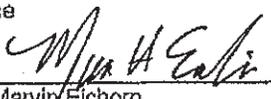
Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ 57,213
Unrestricted Investments	\$ 320,881
Total Cash	\$ 378,094
Total Operating Expenses (Including Interest)	\$ 747,286
less: Non Cash Expenses	\$ 59,695
Total Cash Expenses (TTM)	\$ 687,591
Daily Cash Expenses	\$ 1,884
Days Cash on Hand Ratio	<u>201 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 64,402
+ Depreciation	\$ 55,601
+ Amortization	\$ 2,235
+ Interest Expense	\$ 40,618
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	
EBITDA	\$ 153,182
Total Debt Service (MADS)	\$ 69,404
Debt Service Coverage Ratio	2.21x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 48,185
Unrestricted Investments	\$ 335,612
Total Cash	\$ 383,797
Total Operating Expenses (Including Interest)	\$ 794,117
less: Non Cash Expenses	\$ 57,836
Total Cash Expenses (TTM)	\$ 736,281
Daily Cash Expenses	\$ 2,017
Days Cash on Hand Ratio	190 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between Mizuho Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 13,491
+ Depreciation	\$ 60,683
+ Amortization	\$ 2,028
+ Interest Expense	\$ 41,619
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ 4,622
EBITDA	\$ 122,442
Total Debt Service (MADS)	\$ 67,281
Debt Service Coverage Ratio	<u>1.82x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 8,888
Unrestricted Investments	\$ 388,207
Total Cash	\$ 397,095
Total Operating Expenses (Including Interest)	\$ 821,779
less: Non Cash Expenses	\$ 62,711
Total Cash Expenses (TTM)	\$ 759,068
Daily Cash Expenses	\$ 2,079.64
Days Cash on Hand Ratio	<u>191 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Elchorn
 Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 49,107
+ Depreciation	\$ 65,307
+ Amortization	\$ 4,903
+ Interest Expense	\$ 43,995
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,827
Total Debt Service (MADS)	\$ 65,782
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marylin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 45,004
+ Depreciation	\$ 56,299
+ Amortization	\$ 2,242
+ Interest Expense	\$ 39,641
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 145,463
Total Debt Service (MADS)	\$ 65,742
Debt Service Coverage Ratio	2.21x
Covenant Requirement	1.30x

Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>59,288</u>
+ Depreciation	\$ <u>56,474</u>
+ Amortization	\$ <u>2,232</u>
+ Interest Expense	\$ <u>40,547</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	<u>-</u>
EBITDA	\$ <u>151,385</u>
 Total Debt Service (MADS)	 \$ <u>69,393</u>
 Debt Service Coverage Ratio	 <u>2.18x</u>
Covenant Requirement	<u>1.30x</u>

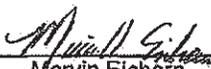
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
 Total Operating Expenses (Including Interest)	 \$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TTM)	\$ <u>-</u>
 Daily Cash Expenses	 \$ <u>-</u>
 Days Cash on Hand Ratio	 <u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ (7,162)
+ Depreciation	\$ 60,678
+ Amortization	\$ 1,859
+ Interest Expense	\$ 42,191
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 102,188
Total Debt Service (MADS)	\$ 67,267
Debt Service Coverage Ratio	<u>1.52x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>23,297</u>
+ Depreciation	\$ 48,742
+ Amortization	\$ 1,149
+ Interest Expense	\$ 43,382
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ <u>121,192</u>
Total Debt Service (MADS)	\$ <u>67,246</u>
Debt Service Coverage Ratio	<u>1.80x</u>
Covenant Requirement	<u>1.30x</u>

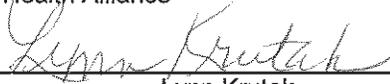
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 60,483
+ Depreciation	\$ 61,111
+ Amortization	\$ 2,211
+ Interest Expense	\$ 42,464
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 151,293
Total Debt Service (MADS)	\$ 67,625
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 86,426
Unrestricted Investments	\$ 284,871
Total Cash	\$ 371,297
Total Operating Expenses (Including Interest)	\$ 699,129
less: Non Cash Expenses	\$ 63,322
Total Cash Expenses (TTM)	\$ 635,807
Daily Cash Expenses	\$ 1,742
Days Cash on Hand Ratio	213 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 41,119
+ Depreciation	\$ 52,865
+ Amortization	\$ 2,233
+ Interest Expense	\$ 42,009
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,438
Total Debt Service (MADS)	\$ 65,754
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 38,364
Unrestricted Investments	\$ 329,369
Total Cash	\$ 367,733
Total Operating Expenses (Including Interest)	\$ 792,216
less: Non Cash Expenses	\$ 55,098
Total Cash Expenses (TTM)	\$ 737,117
Daily Cash Expenses	\$ 2,019
Days Cash on Hand Ratio	182 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Martin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2013

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	<u>\$ 68,859</u>
+ Depreciation	<u>\$ 58,286</u>
+ Amortization	<u>\$ 2,213</u>
+ Interest Expense	<u>\$ 41,226</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary Items	<u> </u>

EBITDA \$ 151,307

Total Debt Service (MADS) \$ 69,360

Debt Service Coverage Ratio 2.18x

Covenant Requirement 1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	<u>\$ 49,266</u>
Unrestricted Investments	<u>\$ 351,725</u>
Total Cash	<u>\$ 400,991</u>

Total Operating Expenses (Including Interest)	<u>\$ 800,349</u>
less: Non Cash Expenses	<u>\$ 60,499</u>
Total Cash Expenses (TTM)	<u>\$ 739,850</u>

Daily Cash Expenses \$ 2,027

Days Cash on Hand Ratio 198 Days

Covenant Requirement 100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 15,340
+ Depreciation	\$ 52,544
+ Amortization	\$ 1,691
+ Interest Expense	\$ 42,734
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 116,931
Total Debt Service (MADS)	\$ 67,257
Debt Service Coverage Ratio	1.74x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 27,419
Unrestricted Investments	\$ 395,346
Total Cash	\$ 422,765
Total Operating Expenses (Including Interest)	\$ 825,612
less: Non Cash Expenses	\$ 54,235
Total Cash Expenses (TTM)	\$ 771,377
Daily Cash Expenses	\$ 2,113
Days Cash on Hand Ratio	200 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 33,771
+ Depreciation	\$ 51,308
+ Amortization	\$ 1,488
+ Interest Expense	\$ 41,598
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 128,165
Total Debt Service (MADS)	\$ 67,254
Debt Service Coverage Ratio	1.91x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 47,024
Unrestricted Investments	\$ 407,932
Total Cash	\$ 454,956
Total Operating Expenses (Including Interest)	\$ 829,866
less: Non Cash Expenses	\$ 52,796
Total Cash Expenses (TTM)	\$ 777,070
Daily Cash Expenses	\$ 2,129
Days Cash on Hand Ratio	214 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 42,447
+ Depreciation	\$ 47,707
+ Amortization	\$ 10,205
+ Interest Expense	\$ 39,725
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 142,532
Total Debt Service (MADS)	\$ 77,187
Debt Service Coverage Ratio	<u>1.85x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Elchorn
Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 50,451</u>
+ Depreciation	<u>\$ 57,953</u>
+ Amortization	<u>\$ 2,233</u>
+ Interest Expense	<u>\$ 39,882</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary Items	<u> </u>
EBITDA	<u>\$ 146,901</u>
Total Debt Service (MADS)	<u>\$ 65,667</u>
Debt Service Coverage Ratio	<u>2.24x</u>
Covenant Requirement	<u>1.30x</u>

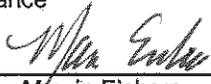
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	<u>\$ -</u>
Unrestricted Investments	<u>\$ -</u>
Total Cash	<u>\$ -</u>
Total Operating Expenses (Including Interest)	<u>\$ -</u>
less: Non-Cash Expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ -</u>
Daily Cash Expenses	<u>\$ -</u>
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,630
+ Depreciation	\$ 56,521
+ Amortization	\$ 2,298
+ Interest Expense	\$ 40,934
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ (2,553)
EBITDA	\$ 148,107
Total Debt Service (MADS)	\$ 69,270
Debt Service Coverage Ratio	2.14x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>62,408</u>
+ Depreciation	\$ <u>59,811</u>
+ Amortization	\$ <u>2,192</u>
+ Interest Expense	\$ <u>41,609</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	\$ <u>-</u>
EBITDA	\$ <u>135,723</u>
Total Debt Service (MADS)	\$ <u>67,286</u>
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

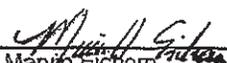
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
Total Operating Expenses (Including Interest)	\$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TTM)	\$ <u>-</u>
Daily Cash Expenses	\$ <u>-</u>
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichom
Title: Senior Vice-President, CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 37,352
+ Depreciation	\$ 51,344
+ Amortization	\$ 1,539
+ Interest Expense	\$ 42,901
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 133,136
Total Debt Service (MADS)	\$ 67,252
Debt Service Coverage Ratio	1.98x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: Lynn Krutak
Print Name: Lynn Krutak
Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 43,001
+ Depreciation	\$ 51,625
+ Amortization	\$ 7,538
+ Interest Expense	\$ 42,868
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 140,875
Total Debt Service (MADS)	\$ 69,886
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 167,099
Unrestricted Investments	\$ 183,585
Total Cash	\$ 350,684
Total Operating Expenses (Including Interest)	\$ 686,573
less: Non Cash Expenses	\$ 59,163
Total Cash Expenses (TTM)	\$ 627,410
Daily Cash Expenses	\$ 1,719
Days Cash on Hand Ratio	<u>204 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 39,641
+ Depreciation	\$ 57,427
+ Amortization	\$ 2,268
+ Interest Expense	\$ 39,479
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,118
 Total Debt Service (MADS)	 \$ 65,751
 Debt Service Coverage Ratio	 <u>2.22x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 57,213
Unrestricted Investments	\$ 320,881
Total Cash	\$ 378,094
 Total Operating Expenses (Including Interest)	 \$ 747,286
less: Non Cash Expenses	\$ 59,895
Total Cash Expenses (TTM)	\$ 687,691
 Daily Cash Expenses	 \$ 1,884
 Days Cash on Hand Ratio	 <u>201 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Elchorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 64,402
+ Depreciation	\$ 55,601
+ Amortization	\$ 2,235
+ Interest Expense	\$ 40,618
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	
EBITDA	\$ 153,182
Total Debt Service (MADS)	\$ 69,404
Debt Service Coverage Ratio	2.21x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 48,185
Unrestricted Investments	\$ 335,612
Total Cash	\$ 383,797
Total Operating Expenses (Including Interest)	\$ 794,117
less: Non Cash Expenses	\$ 57,836
Total Cash Expenses (TTM)	\$ 736,281
Daily Cash Expenses	\$ 2,017
Days Cash on Hand Ratio	190 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	<u>\$ 13,491</u>
+ Depreciation	\$ 60,683
+ Amortization	\$ 2,028
+ Interest Expense	\$ 41,619
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	<u>\$ 122,442</u>
Total Debt Service (MADS)	<u>\$ 67,281</u>

Debt Service Coverage Ratio	<u>1.82x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 8,888
Unrestricted Investments	\$ 388,207
Total Cash	<u>\$ 397,095</u>
Total Operating Expenses (Including Interest)	\$ 821,779
less: Non Cash Expenses	\$ 62,711
Total Cash Expenses (TTM)	<u>\$ 759,068</u>
Daily Cash Expenses	<u>\$ 2,079.64</u>
Days Cash on Hand Ratio	<u>191 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between PNC Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,906
+ Depreciation	\$ 49,984
+ Amortization	\$ 1,540
+ Interest Expense	\$ 42,765
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 145,195
Total Debt Service (MADS)	\$ 67,240
Debt Service Coverage Ratio	2.16x
Covenant Requirement	1.30x

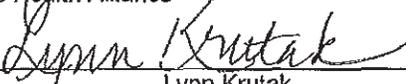
Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ 38,810
Unrestricted Investments	\$ 387,586
Total Cash	\$ 426,396
Total Operating Expenses (Including Interest)	\$ 820,364
less: Non Cash Expenses	\$ 51,524
Total Cash Expenses (TTM)	\$ 768,840
Daily Cash Expenses	\$ 2,106
Days Cash on Hand Ratio	202 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>(7,162)</u>
+ Depreciation	\$ <u>60,678</u>
+ Amortization	\$ <u>1,859</u>
+ Interest Expense	\$ <u>42,191</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	\$ <u>4,622</u>
EBITDA	\$ <u>102,188</u>
Total Debt Service (MADS)	\$ <u>67,267</u>
Debt Service Coverage Ratio	<u>1.52x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ <u>-</u>
Unrestricted Investments	\$ <u>-</u>
Total Cash	\$ <u>-</u>
Total Operating Expenses (Including Interest)	\$ <u>-</u>
less: Non Cash Expenses	\$ <u>-</u>
Total Cash Expenses (TTM)	\$ <u>-</u>
Daily Cash Expenses	\$ <u>-</u>
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 3/31/2015

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	\$ 23,297
+ Depreciation	\$ 48,742
+ Amortization	\$ 1,149
+ Interest Expense	\$ 43,382
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 121,192

Total Debt Service (MADS) \$ 67,246

Debt Service Coverage Ratio 1.80x

Covenant Requirement 1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -

Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -

Daily Cash Expenses \$ -

Days Cash on Hand Ratio N/A Days

Covenant Requirement 100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2014

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 15,340
+ Depreciation	\$ 52,544
+ Amortization	\$ 1,691
+ Interest Expense	\$ 42,734
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 116,931
Total Debt Service (MADS)	\$ 67,257

Debt Service Coverage Ratio	1.74x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 27,419
Unrestricted Investments	\$ 395,346
Total Cash	\$ 422,765

Total Operating Expenses (Including Interest)	\$ 825,612
less: Non Cash Expenses	\$ 54,235
Total Cash Expenses (TTM)	\$ 771,377

Daily Cash Expenses	\$ 2,113
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Days Cash on Hand Ratio	200 Days
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Covenant Requirement	100 Days
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To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Lynn Krutak
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 6/30/2015

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 33,771
+ Depreciation	\$ 51,308
+ Amortization	\$ 1,488
+ Interest Expense	\$ 41,598
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 128,165
Total Debt Service (MADS)	\$ 67,254
Debt Service Coverage Ratio	1.91x
Covenant Requirement,	1.30x

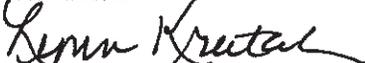
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 47,024
Unrestricted Investments	\$ 407,932
Total Cash	\$ 454,956
Total Operating Expenses (Including Interest)	\$ 829,866
less: Non Cash Expenses	\$ 52,796
Total Cash Expenses (TTM)	\$ 777,070
Daily Cash Expenses	\$ 2,129
Days Cash on Hand Ratio	214 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 29, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2013

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 62,408
+ Depreciation	\$ 59,811
+ Amortization	\$ 2,192
+ Interest Expense	\$ 41,609
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 135,723
Total Debt Service (MADS)	\$ 67,286
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	<u>N/A Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 29, 2013.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Loan Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 9/30/2014

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	\$ 37,352
+ Depreciation	\$ 51,344
+ Amortization	\$ 1,539
+ Interest Expense	\$ 42,901
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 133,136
Total Debt Service (MADS)	\$ 67,252
Debt Service Coverage Ratio	1.98x
Covenant Requirement	1.30x

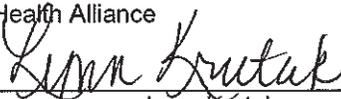
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
 Print Name: Lynn Krutak
 Title: Senior Vice-President CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between SunTrust Bank and Mountain States Health Alliance dated July 30, 2013, we hereby represent and warrant as follows:

Status as of: 12/31/2013

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	\$ 13,491
+ Depreciation	\$ 60,683
+ Amortization	\$ 2,028
+ Interest Expense	\$ 41,619
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ 4,622
EBITDA	\$ 122,442

Total Debt Service (MADS) \$ 67,281

Debt Service Coverage Ratio 1.82x

Covenant Requirement 1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 8,888
Unrestricted Investments	\$ 388,207
Total Cash	\$ 397,095
Total Operating Expenses (Including interest)	\$ 821,779
less: Non Cash Expenses	\$ 62,711
Total Cash Expenses (TTM)	\$ 759,068

Daily Cash Expenses \$ 2,079.64

Days Cash on Hand Ratio 191 Days

Covenant Requirement 100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective July 30, 2013.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice-President, CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 49,107
+ Depreciation	\$ 55,307
+ Amortization	\$ 4,903
+ Interest Expense	\$ 43,995
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,827
Total Debt Service (MADS)	\$ 65,782
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Elchorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance

Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 3/31/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 45,004
+ Depreciation	\$ 56,299
+ Amortization	\$ 2,242
+ Interest Expense	\$ 39,641
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	
EBITDA	\$ 145,463
Total Debt Service (MADS)	\$ 65,742
Debt Service Coverage Ratio	2.21x
Covenant Requirement	1.30x

Days Cash on Hand

~~Required with June and December Reporting Periods~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

(QUARTERLY/ANNUAL) COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing;

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: *Marvin Eichen*
Name: Marvin Eichen
Title: Senior Vice President, CFO

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 3/31/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>59,288</u>
Plus:	
Depreciation and amortization	\$ 58,706
Interest Expense	\$ 40,547
Unrealized losses (gains)	\$ (7,157)
Extraordinary expenses	\$ -
(LOC fees included in interest expense)	\$ (5,351)
(Interest on Trusteed Funds)	\$ (641)
Net Income Available for Debt Service	\$ <u>145,392</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	\$ <u>69,393</u>
Debt Service Coverage Calculated	<u>2.10x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ <u>-</u>
Operating Expenses	\$ -
Less:	
Depreciation and Amortization	\$ -
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ <u>-</u>
Day of Cash Operating Expenses	\$ <u>-</u>
Days Cash on Hand Calculated	<u>N/A Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

QUARTERLY/ANNUAL COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

Marvin E. Gibson

By: _____
Name: Marvin E. Gibson
Title: Senior VP, CFO

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 3/31/14

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 29,567
Plus:	
Depreciation and amortization	\$ 62,537
Interest Expense	\$ 42,191
Unrealized losses (gains)	\$ (36,729)
Extraordinary expenses	\$ 4,622
(LOC fees included in interest expense)	\$ (3,314)
(Interest on Trusteed Funds)	\$ (869)
Net Income Available for Debt Service	\$ 98,005
Maximum Annual Debt Service on all Outstanding Indebtedness	\$ 67,267
Debt Service Coverage Calculated	1.46x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ -
Operating Expenses	\$ -
Less:	
Depreciation and Amortization	\$ -
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Day of Cash Operating Expenses	\$ -
Days Cash on Hand Calculated	N/A Days
Minimum Days Cash on Hand Required	100 Days

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending March 31, 2015 in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 3/31/2015

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>24,015</u>
Plus:	
Depreciation and amortization	\$ 49,891
Interest Expense	\$ 43,382
Unrealized losses (gains)	\$ (718)
Extraordinary expenses	\$ 4,622
(LOC fees included in interest expense)	\$ (2,214)
(Interest on Trusteed Funds)	\$ (381)
Net Income Available for Debt Service	\$ <u>118,597</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	\$ <u>67,246</u>
Debt Service Coverage Calculated	<u>1.76x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ -
Operating Expenses	\$ -
Less:	
Depreciation and Amortization	\$ -
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Day of Cash Operating Expenses	\$ -
Days Cash on Hand Calculated	<u>N/A Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2011

Debt Service Coverage

Trailing 12-Month

Excess Revenue Over Expenses	<u>\$ 60,483</u>
+ Depreciation	<u>\$ 61,111</u>
+ Amortization	<u>\$ 2,211</u>
+ Interest Expense	<u>\$ 42,464</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary Items	<u> </u>
EBITDA	<u>\$ 151,293</u>
Total Debt Service (MADS)	<u>\$ 67,625</u>

Debt Service Coverage Ratio	<u>2.24x</u>
Covenant Requirement	<u>1.30x</u>

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	<u>\$ 86,426</u>
Unrestricted Investments	<u>\$ 284,871</u>
Total Cash	<u>\$ 371,297</u>
Total Operating Expenses (including Interest)	<u>\$ 699,129</u>
less: Non Cash Expenses	<u>\$ 63,322</u>
Total Cash Expenses (TTM)	<u>\$ 635,807</u>
Daily Cash Expenses	<u>\$ 1,742</u>
Days Cash on Hand Ratio	<u>213 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance
 By: 
 Print Name: Marvin Elchorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 6/30/2012

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 41,119
+ Depreciation	\$ 52,865
+ Amortization	\$ 2,233
+ Interest Expense	\$ 42,009
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 146,438
Total Debt Service (MADS)	\$ 65,754
Debt Service Coverage Ratio	2.23x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ 38,364
Unrestricted Investments	\$ 329,369
Total Cash	\$ 367,733
Total Operating Expenses (Including Interest)	\$ 792,215
less: Non Cash Expenses	\$ 55,098
Total Cash Expenses (TTM)	\$ 737,117
Daily Cash Expenses	\$ 2,019
Days Cash on Hand Ratio	182 Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Eichorn
 Title: Senior Vice President & CFO

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 6/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 68,859</u>
Plus:	
Depreciation and amortization	<u>\$ 60,499</u>
Interest Expense	<u>\$ 41,226</u>
Unrealized losses (gains)	<u>\$ (19,278)</u>
Extraordinary expenses	<u>\$ -</u>
(LOC fees included in interest expense)	<u>\$ (5,412)</u>
(Interest on Trusteed Funds)	<u>\$ (833)</u>
Net Income Available for Debt Service	<u>\$ 145,061</u>
Maximum Annual Debt Service on all Outstanding indebtedness	<u>\$ 69,360</u>
Debt Service Coverage Calculated	<u>2.09x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	<u>\$ 400,991</u>
Operating Expenses	<u>\$ 800,349</u>
Less:	
Depreciation and Amortization	<u>\$ 60,499</u>
Other excluded expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ 739,850</u>
Day of Cash Operating Expenses	<u>\$ 2,027</u>
Days Cash on Hand Calculated	<u>198 Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending June 30, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice-President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 6/30/2014

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 43,636
Plus:	
Depreciation and amortization	\$ 54,235
Interest Expense	\$ 42,734
Unrealized losses (gains)	\$ (28,296)
Extraordinary expenses	\$ 4,622
(LOC fees included in interest expense)	\$ (2,537)
(Interest on Trusteed Funds)	\$ (666)
Net Income Available for Debt Service	\$ 113,728
Maximum Annual Debt Service on all Outstanding indebtedness	\$ 67,257
Debt Service Coverage Calculated	1.69x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ 422,765
Operating Expenses	\$ 825,612
Less:	
Depreciation and Amortization	\$ 54,235
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ 771,377
Day of Cash Operating Expenses	\$ 2,113
Days Cash on Hand Calculated	200 Days
Minimum Days Cash on Hand Required	100 Days

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending June 30, 2015, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior VP & CFO

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 06/30/2015

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 30,423</u>
Plus:	
Depreciation and amortization	<u>\$ 52,796</u>
Interest Expense	<u>\$ 41,598</u>
Unrealized losses (gains)	<u>\$ 3,348</u>
Extraordinary expenses	<u>\$ -</u>
(LOC fees included in interest expense)	<u>\$ (2,183)</u>
(Interest on Trusteed Funds)	<u>\$ (321)</u>
Net Income Available for Debt Service	<u>\$ 125,661</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	<u>\$ 67,254</u>
Debt Service Coverage Calculated	<u>1.87x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	<u>\$ 454,956</u>
Operating Expenses	<u>\$ 829,866</u>
Less:	
Depreciation and Amortization	<u>\$ 52,796</u>
Other excluded expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ 777,070</u>
Day of Cash Operating Expenses	<u>\$ 2,129</u>
Days Cash on Hand Calculated	<u>214 Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 42,447
+ Depreciation	\$ 47,707
+ Amortization	\$ 10,205
+ Interest Expense	\$ 39,725
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary items	\$ -
EBITDA	\$ 142,532
Total Debt Service (MADS)	\$ 77,187
Debt Service Coverage Ratio	1.85x
Covenant Requirement	1.30x

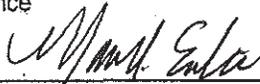
Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marilyn Eichorn
 Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 9/30/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 50,451
+ Depreciation	\$ 57,953
+ Amortization	\$ 2,233
+ Interest Expense	\$ 39,882
+ Taxes	\$ -
+ Non-Cash Impairment Losses	\$ -
+ Extraordinary Items	\$ -
EBITDA	\$ 146,901
Total Debt Service (MADS)	\$ 65,667
Debt Service Coverage Ratio	2.24x
Covenant Requirement	1.30x

Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	\$ -
Unrestricted Investments	\$ -
Total Cash	\$ -
Total Operating Expenses (Including Interest)	\$ -
less: Non Cash Expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Daily Cash Expenses	\$ -
Days Cash on Hand Ratio	N/A Days
Covenant Requirement	100 Days

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
 Print Name: Marvin Elchorn
 Title: Senior Vice President & CFO

QUARTERLY/ANNUAL COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30, 2012, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: 

Name:

Marilyn H. Eichorn

Title:

Senior Vice President & CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 9/30/2012

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 50,630</u>
Plus:	
Depreciation and amortization	<u>\$ 58,819</u>
Interest Expense	<u>\$ 40,934</u>
Unrealized losses (gains)	<u>\$ (4,829)</u>
Extraordinary expenses	<u>\$ (2,553)</u>
(LOC fees included in interest expense)	<u>\$ (5,261)</u>
(Interest on Trusteed Funds)	<u>\$ (580)</u>
Net Income Available for Debt Service	<u>\$ 137,160</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	<u>\$ 69,270</u>
Debt Service Coverage Calculated	<u>1.98x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	<u>\$ -</u>
Operating Expenses	<u>\$ -</u>
Less:	
Depreciation and Amortization	<u>\$ -</u>
Other excluded expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ -</u>
Day of Cash Operating Expenses	<u>\$ -</u>
Days Cash on Hand Calculated	<u>N/A Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

QUARTERLY/ANNUAL COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30 2013, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: 

Name: Marvin Eichorn

Title: Senior Vice President, CFO

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 9/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>62,408</u>
Plus:	
Depreciation and amortization	\$ 62,003
Interest Expense	\$ 41,609
Unrealized losses (gains)	\$ (34,920)
Extraordinary expenses	\$ -
(LOC fees included in interest expense)	\$ (4,887)
(Interest on Trusteed Funds)	\$ (765)
Net Income Available for Debt Service	\$ <u>125,448</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	\$ <u>67,286</u>
Debt Service Coverage Calculated	<u>1.86x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ <u>-</u>
Operating Expenses	\$ -
Less:	
Depreciation and Amortization	\$ -
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ <u>-</u>
Day of Cash Operating Expenses	\$ <u>-</u>
Days Cash on Hand Calculated	<u>N/A Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

QUARTERLY/ANNUAL COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending September 30, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: 
Name: Lynn Krutak
Title: Senior Vice President + CFO

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 9/30/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ 28,275
Plus:	
Depreciation and amortization	\$ 52,883
Interest Expense	\$ 42,901
Unrealized losses (gains)	\$ 9,078
Extraordinary expenses	\$ -
(LOC fees included in interest expense)	\$ (2,190)
(Interest on Trusteed Funds)	\$ (614)
Net Income Available for Debt Service	\$ 130,333
Maximum Annual Debt Service on all Outstanding Indebtedness	\$ 67,252
Debt Service Coverage Calculated	1.94x
Debt Service Coverage Required	1.30x

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ -
Operating Expenses	\$ -
Less:	
Depreciation and Amortization	\$ -
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ -
Day of Cash Operating Expenses	\$ -
Days Cash on Hand Calculated	N/A Days
Minimum Days Cash on Hand Required	100 Days

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance, dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2010

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 43,001</u>
+ Depreciation	<u>\$ 51,625</u>
+ Amortization	<u>\$ 7,538</u>
+ Interest Expense	<u>\$ 42,988</u>
+ Taxes	<u>\$ -</u>
+ Non-Cash Impairment Losses	<u>\$ -</u>
+ Extraordinary items	<u> </u>
EBITDA	<u>\$ 140,875</u>
Total Debt Service (MADS)	<u>\$ 69,886</u>
Debt Service Coverage Ratio	<u>2.02x</u>
Covenant Requirement	<u>1.30x</u>

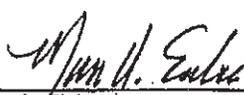
Days Cash on Hand

(Required with June and December Reporting Periods)

Cash	<u>\$ 167,099</u>
Unrestricted Investments	<u>\$ 183,585</u>
Total Cash	<u>\$ 350,684</u>
Total Operating Expenses (Including Interest)	<u>\$ 686,573</u>
less: Non Cash Expenses	<u>\$ 59,163</u>
Total Cash Expenses (TTM)	<u>\$ 627,410</u>
Daily Cash Expenses	<u>\$ 1,719</u>
Days Cash on Hand Ratio	<u>204 Days</u>
Covenant Requirement	<u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Eichorn
Title: Senior Vice President & CFO

Mountain States Health Alliance
Covenant Compliance Certificate

In accordance with the terms of the Letter of Credit and Security Agreement between US Bank and Mountain States Health Alliance dated September 29, 2010, we hereby represent and warrant as follows:

Status as of: 12/31/2011

Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>39,641</u>
+ Depreciation	\$ <u>57,427</u>
+ Amortization	\$ <u>2,268</u>
+ Interest Expense	\$ <u>39,479</u>
+ Taxes	\$ <u>-</u>
+ Non-Cash Impairment Losses	\$ <u>-</u>
+ Extraordinary Items	<u>-</u>
EBITDA	\$ <u>146,118</u>
 Total Debt Service (MADS)	 \$ <u>65,751</u>
 Debt Service Coverage Ratio	 <u>2.22x</u>
 Covenant Requirement	 <u>1.30x</u>

Days Cash on Hand

~~(Required with June and December Reporting Periods)~~

Cash	\$ <u>57,213</u>
Unrestricted Investments	\$ <u>320,881</u>
Total Cash	\$ <u>378,094</u>
 Total Operating Expenses (Including Interest)	 \$ <u>747,286</u>
less: Non Cash Expenses	\$ <u>59,695</u>
Total Cash Expenses (TTM)	\$ <u>687,691</u>
 Daily Cash Expenses	 \$ <u>1,884</u>
 Days Cash on Hand Ratio	 <u>201 Days</u>
 Covenant Requirement	 <u>100 Days</u>

To the best of the knowledge and belief of the signer hereof, the undersigned does certify that the foregoing certificate is true and correct as of this date, and that the Borrower is in compliance with all terms and conditions of the Letter of Credit and Security Agreement dated effective September 29, 2010.

Mountain States Health Alliance

By: 
Print Name: Marvin Elchorn
Title: Senior Vice President & CFO

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2012, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: 
Name: Manjiv Eichen
Title: Senior VP & CFO

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 12/31/2012

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 64,402</u>
Plus:	
Depreciation and amortization	<u>\$ 57,836</u>
Interest Expense	<u>\$ 40,618</u>
Unrealized losses (gains)	<u>\$ (9,675)</u>
Extraordinary expenses	<u>\$ -</u>
(LOC fees included in interest expense)	<u>\$ (5,301)</u>
(Interest on Trusteed Funds)	<u>\$ (587)</u>
Net Income Available for Debt Service	<u>\$ 147,293</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	<u>\$ 69,404</u>
Debt Service Coverage Calculated	<u>2.12x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	<u>\$ 383,797</u>
Operating Expenses	<u>\$ 794,117</u>
Less:	
Depreciation and Amortization	<u>\$ 57,836</u>
Other excluded expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ 736,281</u>
Day of Cash Operating Expenses	<u>\$ 2,017</u>
Days Cash on Hand Calculated	<u>190 Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing;

Exceptions: _____

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2013 in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE



By:

Name: Marvyn Eichhorn

Title: Senior Vice President, CFO

Mountain States Health Alliance

Compliance Certificate - Schedule I
For the Period Ended 12/31/2013

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	<u>\$ 54,489</u>
Plus:	
Depreciation and amortization	<u>\$ 62,711</u>
Interest Expense	<u>\$ 41,619</u>
Unrealized losses (gains)	<u>\$ (40,999)</u>
Extraordinary expenses	<u>\$ 4,622</u>
(LOC fees included in interest expense)	<u>\$ (4,285)</u>
(Interest on Trusteed Funds)	<u>\$ (902)</u>
Net Income Available for Debt Service	<u>\$ 117,255</u>
Maximum Annual Debt Service on all Outstanding Indebtedness	<u>\$ 67,281</u>
Debt Service Coverage Calculated	<u>1.74x</u>
Debt Service Coverage Required	<u>1.30x</u>

(b) Liquidity Covenant

(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	<u>\$ 397,095</u>
Operating Expenses	<u>\$ 821,779</u>
Less:	
Depreciation and Amortization	<u>\$ 62,711</u>
Other excluded expenses	<u>\$ -</u>
Total Cash Expenses (TTM)	<u>\$ 759,068</u>
Day of Cash Operating Expenses	<u>\$ 2,080</u>
Days Cash on Hand Calculated	<u>191 Days</u>
Minimum Days Cash on Hand Required	<u>100 Days</u>

[QUARTERLY/ANNUAL] COMPLIANCE CERTIFICATE

U.S. Bank National Association
1349 W. Peachtree St. NW, Ste. 1050
Atlanta, Georgia 30309
Attention: Vice President, National Healthcare Division
404.898.8898 (FAX)

U.S. Bank National Association
One U.S. Bank Plaza
7th Street & Washington Avenue, SL-MO-T12M
St. Louis, Missouri 63101
Attention: Capital Markets Division
(314) 418-3571 (FAX)

Ladies and Gentlemen:

Reference is hereby made to that certain Reimbursement Agreement dated as of June 29, 2012 (the "Reimbursement Agreement"), by and between Mountain States Health Alliance (together with any other Members of the Obligated Group, as defined in the Reimbursement Agreement, the "Corporation") and U.S. Bank National Association (the "Bank"), as the same may from time to time be amended, modified, extended, renewed or restated. All capitalized terms used and not otherwise defined herein shall have the respective meanings ascribed to them in the Reimbursement Agreement.

The Borrower hereby certifies to the Bank that as of the date hereof:

(a) a review of the activities of the Borrower has been made under my supervision with a view to determining whether the Borrower has fulfilled all of its obligations under the Reimbursement Agreement and the other Credit Documents;

(b) except as set forth below, the Borrower has fulfilled its obligations under the Credit Documents and all representations made therein continue to be true and correct in all material respects;

Exceptions: _____

_____;

(c) except as set forth below, no Event of Default under or within the meaning of the Reimbursement Agreement has occurred and continuing:

Exceptions: _____

_____;

(d) the financial statements of the Borrower delivered to you with this Certificate are true, correct and complete in all material respects and have been prepared in accordance with accounting principles generally accepted in the United States of America or, in the case of any interim financial

statements, on a basis substantially consistent with the audited financial statements (subject, in the case of any interim financial statements, to normal year-end adjustments and absence of footnote disclosures);

(e) Schedule I to this Certificate contains computations evidencing the Borrower's compliance with the financial covenants set forth in Section 4.22 of the Reimbursement Agreement as of and for the period ending December 31, 2014, in each case calculated for the requested periods and in accordance with the requirements of the Reimbursement Agreement and the Master Indenture; and

(f) any other financial or other details, information and material as you have requested to evidence such compliance delivered herewith are true and correct.

Very truly yours,

MOUNTAIN STATES HEALTH ALLIANCE

By: Lynn Krutak
Name: Lynn Krutak
Title: Senior Vice President, CFO

Schedule I to Compliance Certificate

Mountain States Health Alliance
Compliance Certificate - Schedule I
For the Period Ended 12/31/2014

Section 4.22 - Financial Covenants

(a) Debt Service Coverage

	Trailing 12-Month
Excess Revenue Over Expenses	\$ <u>28,210</u>
Plus:	
Depreciation and amortization	\$ 51,524
Interest Expense	\$ 42,765
Unrealized losses (gains)	\$ 22,696
Extraordinary expenses	\$ -
(LOC fees included in interest expense)	\$ (2,245)
(Interest on Trusteed Funds)	\$ (451)
 Net Income Available for Debt Service	 \$ <u>142,499</u>
 Maximum Annual Debt Service on all Outstanding Indebtedness	 \$ <u>67,240</u>
 Debt Service Coverage Calculated	 <u>2.12x</u>
 Debt Service Coverage Required	 <u>1.30x</u>

(b) Liquidity Covenant

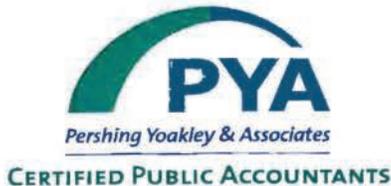
(Required with June and December Reporting Periods)

Unrestricted Cash and Investments	\$ <u>426,396</u>
 Operating Expenses	 \$ 820,364
Less:	
Depreciation and Amortization	\$ 51,524
Other excluded expenses	\$ -
Total Cash Expenses (TTM)	\$ <u>768,840</u>
 Day of Cash Operating Expenses	 \$ <u>2,106</u>
 Days Cash on Hand Calculated	 <u>202 Days</u>
 Minimum Days Cash on Hand Required	 <u>100 Days</u>

Exhibit 11.4

Attachment E

Mountain States Officer's Certificates



Pershing Yoakley & Associates, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
(p) (865) 673-0844 (f) (865) 673-0173
(w) www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance and subsidiaries for the year ended June 30, 2010, and have issued our report thereon dated October 25, 2010. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2010 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2010, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the board of directors and management of Mountain States Health Alliance and the Bank of New York, as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other than these specified parties.

Knoxville, Tennessee
October 25, 2010

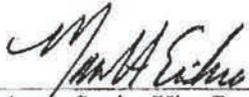
Pershing Yoakley & Associates, P.C.

OFFICER'S CERTIFICATE

TO: The Bank of New York, Master Trustee

In accordance with Article Six, Section 6.6 (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York, the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2010 is 2.08 to 1.00. The Historical Maximum Annual Debt Service Coverage ratio of the Obligated Group for the year ended June 30, 2010 is 1.83 to 1.00.

A report from the independent auditor whose report accompanies the audited financial statements of the Obligated Group and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.



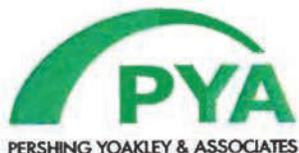
Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

**HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO**

**MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)**

Year Ended June 30, 2010

Income available for debt service - Historical	<u>\$ 136,023</u>
Income available for maximum annual debt service	<u>\$ 141,077</u>
Historical debt service requirement	<u>\$ 65,285</u>
Historical maximum annual debt service requirement	<u>\$ 77,187</u>
Historical debt service coverage ratio	<u>2.08</u>
Historical maximum annual debt service coverage ratio	<u>1.83</u>



PERSHING YOAKLEY & ASSOCIATES, P.C.
Certified Public Accountants
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919

p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance for the year ended June 30, 2011, and have issued our report thereon dated October 26, 2011. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2011 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2011, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the Board of Directors and management of Mountain States Health Alliance and the Bank of New York Mellon Trust Company, N.A., as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other than those specified parties.

Pershing Yoakley: Accountant PC

Knoxville, Tennessee
October 26, 2011



OFFICER'S CERTIFICATE

TO: The Bank of New York, Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York, the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2011 is 2.17 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2011 is 2.26 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.



Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

**HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO**

**MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)**

Year Ended June 30, 2011

Income available for debt service - Historical	<u>\$ 145,340</u>
Income available for maximum annual debt service	<u>\$ 148,528</u>
Historical debt service requirement	<u>\$ 67,129</u>
Historical maximum annual debt service requirement	<u>\$ 65,678</u>
Historical debt service coverage ratio	<u>2.17</u>
Historical maximum annual debt service coverage ratio	<u>2.26</u>



PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
p: (865) 673-0844 | f: (865) 673-0173
www.pyapc.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America, the consolidated financial statements of Mountain States Health Alliance for the year ended June 30, 2012, and have issued our report thereon dated October 26, 2012. We have also audited the accompanying schedule of the historical debt service coverage ratio and historical maximum annual debt service coverage ratio of the Mountain States Health Alliance Obligated Group (the Group) for the year ended June 30, 2012 as defined by the Amended and Restated Master Trust Indenture dated February 1, 2000. This schedule is the responsibility of the Group's management. Our responsibility is to express an opinion on this schedule based on our audit.

We conducted our audit of the schedule in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the schedule is free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purposes of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the schedule. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall schedule presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the schedule referred to above presents fairly, in all material respects, the historical debt service coverage ratio and the historical maximum annual debt service coverage ratio of the Group for the year ended June 30, 2012, in conformity with the Amended and Restated Master Trust Indenture dated February 1, 2000.

This report is intended solely for the information and use of the Board of Directors and management of Mountain States Health Alliance and the Bank of New York Mellon Trust Company, N.A., as Master Trustee under the Amended and Restated Master Trust Indenture dated February 1, 2000, and is not intended to be and should not be used by anyone other than those specified parties.

Pershing Yoakley: Associates PC

Knoxville, Tennessee
October 26, 2012

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2012 is 1.33 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2012 is 1.89 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.



Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO
MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)
Year Ended June 30, 2012

Income available for debt service - Historical	<u>\$ 145,011</u>
Income available for maximum annual debt service	<u>\$ 145,732</u>
Historical debt service requirement	<u>\$ 61,573</u>
Historical maximum annual debt service requirement	<u>\$ 77,211</u>
Historical debt service coverage ratio	<u>2.36</u>
Historical maximum annual debt service coverage ratio	<u>1.89</u>

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2013 is 2.02 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2013 is 1.80 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.



Marvin Eichorn, Senior Vice President and
Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO
MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)
Year Ended June 30, 2013

Income available for debt service - Historical	<u>\$ 132,740</u>
Income available for maximum annual debt service	<u>\$ 133,035</u>
Historical debt service requirement	<u>\$ 65,870</u>
Historical maximum annual debt service requirement	<u>\$ 73,739</u>
Historical debt service coverage ratio	<u>2.02</u>
Historical maximum annual debt service coverage ratio	<u>1.80</u>

OFFICER'S CERTIFICATE

TO: The Bank of New York Mellon Trust Company, N.A., Master Trustee

In accordance with Article Six, Section 6.6. (b) of the Amended and Restated Master Trust Indenture dated February 1, 2000 between Mountain States Health Alliance and The Bank of New York Mellon Trust Company, N.A., the Master Trustee, all insurance required by Article 5 of the Amended and Restated Master Trust Indenture has been obtained and is in full force and effect. To the best of our knowledge, neither Mountain States Health Alliance nor any other Obligated Issuer, its members as defined in the Amended and Restated Master Trust Indenture, is in default in the performance of any debt covenant contained in the Amended and Restated Master Trust Indenture dated February 1, 2000. The Historical Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2014 is 1.82 to 1.00. The Historical Maximum Annual Debt Service Coverage Ratio of the Obligated Group for the year ended June 30, 2014 is 1.75 to 1.00.

A report from the independent auditor whose report accompanies the audited consolidated financial statements and who has audited the schedule of historical debt service coverage ratio and historical maximum annual debt service coverage ratio is attached hereto.



Lynn Krutak, Chief Financial Officer
Mountain States Health Alliance
The Obligated Group Agent

HISTORICAL DEBT SERVICE COVERAGE RATIO
and
HISTORICAL MAXIMUM ANNUAL DEBT SERVICE COVERAGE RATIO

MOUNTAIN STATES HEALTH ALLIANCE OBLIGATED GROUP
(Dollars in Thousands)

Year Ended June 30, 2014

Income available for debt service - Historical	<u>\$ 129,019</u>
Income available for maximum annual debt service	<u>\$ 129,271</u>
Historical debt service requirement	<u>\$ 70,802</u>
<i>Historical maximum annual debt service requirement</i>	<u>\$ 73,905</u>
Historical debt service coverage ratio	<u>1.82</u>
Historical maximum annual debt service coverage ratio	<u>1.75</u>

March 16, 2016

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Tennessee Department of Health's Request for an Addendum to the Application for a Certificate of Public Advantage

Dear Ms. Thigpen:

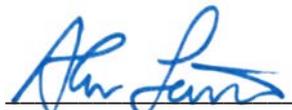
The following information is being provided in response to your letter dated February 29, 2016, relating to the Department of Health's request for an addendum to the application for issuance of a Certificate of Public Advantage ("COPA"). Specifically, we wish to address the Department's objectives and positions raised in your January 15, 2016, written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report" and identify where each objective/position is addressed in the COPA Application submitted on February 16, 2016. Each objective/position posed in your January 15th letter is set forth in its entirety in the attached Addendum together with the location in the Application where that objective/position is addressed. We have also provided an explanation about how the Application section responds to the Department's observations and positions where appropriate.

Additionally, we have included information about the recent announcement that Wellmont's Chief Financial Officer, Alice Pope, will be joining HonorHealth, addressed a technical correction in Section 6 of the Application and accompanying Exhibits, and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E.

We appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Sincerely,

Mountain States Health Alliance
President &
Chief Executive Officer



Alan Levine

Wellmont Health System
President &
Chief Executive Officer



Bart Hove

Enclosure

CC: Valerie Nagoshiner
Malaka Watson
Jeff Ockerman

ADDENDUM #1 TO THE

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: March 16, 2016

MARCH, 2016

Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively referred to as the "Applicants") submitted an application (the "Application") to the Tennessee Department of Health on February 16, 2016 for issuance of a Certificate of Public Advantage ("COPA").

The Tennessee Department of Health (the "Department") has requested that the Applicants provide an addendum to the Application to address the Department's objectives and positions raised in the Department's January 15, 2016 letter, which was written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report."

Each objective/position posed in the Department's January 15th letter is set forth in its entirety below, together with the location in the Application where that objective/position is addressed. The Applicants have also provided an explanation about how that particular section (or sections) responds to the Department's observations and positions where appropriate (Section 1 below).

Additionally, the Applicants wish to formally notify the Department of Alice Pope's planned departure from Wellmont Health System (Section 2 below), addressed a technical correction in Section 6 of the Application and accompanying Exhibits (Section 3 below), and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E (Section 4 below).

SECTION 1: RESPONSE TO THE DEPARTMENT'S JANUARY 15, 2016 LETTER

Observation #1 - Geographic Service Area

The report does not include counties in Kentucky and North Carolina in the geographic service area while the Letter of Intent, submitted September 16, 2015, does include these counties.

Department Position:

Consistent with department rule, "[i]f the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the application, a description of how and why the proposed geographic area differs and why changes are proposed" is required.

The department notes the Kentucky and North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. Unless the application, when it is submitted, includes a reasonable justification to exclude the Kentucky and North Carolina counties, the department will consider these counties, which are contiguous to counties with facilities of the New Health System, to be included in the service area.

Applicants' Response:

As the Department is aware, "geographic service area" is not defined in either the Tennessee COPA statute²⁴ or regulations.²⁵ A healthcare geographic service area may be defined in different ways, including by patient origin data, location of services, geographic features, political boundaries, population, and/or health resources. Since the Tennessee COPA statute and regulations do not define "geographic service area," the Applicants looked to the regulatory language for guidance. Tennessee Rules section 1200-38-01-.02(2)(a)(7) states:

If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed; [*emphasis added*]

For purposes of completing the COPA Application, the Applicants have interpreted the "proposed geographic service area" to mean the geographic area where the Applicants propose to conduct business as the New Health System.

The Applicants have historically served *patients* from a twenty-nine county area, which includes counties in Tennessee, Virginia, Kentucky, and North Carolina. While the Applicants serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, Wellmont and Mountain States only have facilities and locations in Tennessee and Virginia. All of the Wellmont and Mountain States physical facilities and provider locations are located in Tennessee or Virginia and are subject to state regulations only in these two states. To the extent the Applicants draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Applicants' facilities and provider locations in Tennessee and Virginia.

Section 5 of the Application provides a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. While the Applicants recognize that "geographic service area" may be defined in different ways, the Applicants have defined the "proposed geographic service area" in the COPA Application as the twenty-one counties in Tennessee and Virginia where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Tennessee and Virginia counties in which the Applicants have locations and facilities and serve residents, and all locations and providers that will be under the control of the Applicants and subject to any regulation under the COPA or Cooperative Agreement. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured.

²⁴ Tennessee Code Section 68-11-1301 et seq.

²⁵ Tenn. Comp. R. & Regs 1200-38-01-.01 et seq.

Since Wellmont and Mountain States have only operated facilities in Tennessee and Virginia over the five years preceding the application, the proposed geographic service area for the COPA Application does not differ from the service areas where the Applicants have conducted business over the five years preceding the Application.

The Department correctly notes that the two Kentucky counties and six North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. As explained above, a healthcare "service area" may be defined in different ways. Both Wellmont and Mountain States have served *patients* from a twenty-nine county area that includes counties in Tennessee, Virginia, Kentucky, and North Carolina. However, Wellmont and Mountain States only have facilities in Tennessee and Virginia. As shown in the tables below, which is based on the same discharge data used in the Application and published by Tennessee and Virginia, patients from the six North Carolina counties identified in the 29-county area account for one half of one percent (0.5%) of the combined patient discharges. Patients from the two Kentucky counties identified in the 29-county area account for less than one half of one percent (0.4%) of the combined patient discharges. Ninety-eight percent (98%) of the combined patient discharges come from the proposed geographic service area - the 21 counties in Tennessee and Virginia.

Patient County	With MDC 19 and 20					
	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	59,594	35,810	95,404	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	58,441	35,075	93,516	98.1%	97.9%	98.0%
Extended Service Area - NC**	456	35	491	0.8%	0.1%	0.5%
Extended Service Area - KY***	129	267	396	0.2%	0.7%	0.4%
All Other Counties	568	433	1,001	1.0%	1.2%	1.0%

Patient County	Without MDC 19 and 20					
	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	53,822	34,514	88,336	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	52,835	33,828	86,663	98.2%	98.0%	98.1%
Extended Service Area - NC**	443	34	477	0.8%	0.1%	0.5%
Extended Service Area - KY***	123	263	386	0.2%	0.8%	0.4%
All Other Counties	421	389	810	0.8%	1.1%	0.9%

Notes:

Excludes DRG 795

Excludes Takoma Regional Hospital

*Includes the 21 counties and 2 independent cities across Tennessee and Virginia

**Includes the following six North Carolina counties: Ashe, Avery, Madison, Mitchell, Watauga, and Yancey

***Includes the following two Kentucky Counties: Harlan and Letcher

For the reasons stated above, the Applicants believe it is appropriate to define the geographic service area for purposes of the COPA Application as the twenty-one counties in Tennessee and Virginia.

Observation #2 - Prevention Services for all Categories of Payers

The description in the report of prevention services for all categories of payers lacks detail. For example, substance abuse prevention is the only specific example provided.

Department Position:

It is the department's position that, for the application to be deemed complete, prevention services will need to be more specifically enumerated. Consistent with department rule, the Cooperative Agreement must detail the "[p]roposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements...."²⁶

Applicants' Response:

In Sections 11.i and 11.j of the Application, the Applicants outline their commitments to improving community health through investment of not less than \$75 million over ten years in science and evidence-based population health improvement. Specifically, on pages 86-88 of the Application, the Applicants address the use of cost savings to fund prevention services across all payer groups. The Applicants interpret "such as" in the regulations cited by the Department to indicate that the proposed use of cost savings may be used for these types of programs or other types of programs that are designed to achieve long-term population health improvements. The Applicants expect that low or no-cost services such as screening programs and disease management programs will be essential elements of the plan to achieve long-term population health improvements as outlined in the Application. Additionally, the Applicants believe that focusing these low or no-cost programs for specific populations will likely yield the greatest long-term population health improvements. For example, immunization programs for children are well-established and well-funded in the region. However, improvements could be made with respect to immunization programs for pneumonia, flu, and HPV by targeting specific populations to help achieve greater results. The Applicants intend to invest in population health improvement efforts that generate more focused and meaningful value-based spending in the region. The sections of the Application addressing this position are included below for reference:

²⁶ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix)(II).

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

RESPONSE: The New Health System is committed to improving community health through investment of not less than \$75 million over ten years in science and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For example, the Northeast region²⁷ ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with

²⁷ The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. See <https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf> accessed February 4, 2016.

health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least \$140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; develop community-based mental health resources such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Observation #3 - Equity

The explanation of how the New Health System will provide equitable health services with respect to maintaining quality and competition within the service area needs further explanation.²⁸ The department acknowledges the report includes a discussion of access to services in rural areas.

²⁸ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)12(iii).

Still, the document primarily focuses on contracts with health plans and does not discuss the impact of the proposed merger on other payers and their respective populations, including Medicaid and Medicare populations and people without insurance.

Department Position

Consistent with department rules, the application should include policies that specifically address Medicaid and Medicare populations and people without insurance.²⁹ Moreover, the population health improvement plan detailed in the application should cover all residents in the geographic service area.

Applicant's Response:

As noted in Section 11.g.iii.III of the COPA Application, Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid population are housed within Mountain States. As part of the COPA Application, the Applicants provided the State with the current Charity Care and related policies of both Wellmont and Mountain States in the following exhibits:

Exhibit 8.4 - Attachment A	Mountain States' Charity Care Policy
Exhibit 8.4 - Attachment B	Mountain States' Credit and Collection Policy - Patient Accounts
Exhibit 8.4 - Attachment C	Mountain States' Collection Agency Process - Fiscal Services
Exhibit 8.4 - Attachment D	Mountain States' Code of Ethics and Business Conduct
Exhibit 8.5 - Attachment A	Wellmont's Patient Bill of Rights
Exhibit 8.5 - Attachment B	Wellmont's Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

As explained on pages 73-76 of the Application, the New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. If the COPA is granted, the Applicants intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Applicants and consistent with the IRS's final 501(r) rules. The New Health System is a shell entity at this point with no authority to implement charity care or other policies that would govern the operations of the merged enterprise. However, as evidence of the Applicant's commitment to implement similar policies if the COPA is granted, the Applicants have committed in the executed

²⁹ Tennessee Department of Health Rule 1200-38-01-.02(2Xa)13(vii)(III)III[A-D].

Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Applicants.³⁰

To further address the Department's interest in the New Health System's provision of equitable health services, the Applicants address each category of patients on pages 74-76 of the Application. This section is included below for reference:

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured

³⁰ See COPA Application **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance, Section 1.02 "Community Benefit."

population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.
- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

Observation #4 - Health of the Region and Population Health Disparities

The identification and discussion of population health disparities is limited. While the report briefly highlights differences in health behaviors and outcomes among geographic entities, the report does not discuss other groups that often experience health disparities, e.g., racial/ethnic minority, rural and urban, age and gender disparities. The department also notes the report does not address physical activity, one of the Tennessee State Health Plan "Big Three +1" health issues (physical inactivity, obesity, tobacco use and substance abuse). As you know, evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health.

Department Position

For an application to be deemed complete, granular detail is needed regarding factors that influence the health and health disparities of counties, communities, and groups within them, particularly as it relates to the applicants' current assessment of existing trends and long-term population health outcomes.

The department also notes that, should a COPA be issued, the New Health System will be responsible for population health in the region for an indefinite period of time. The department is interested in additional longitudinal plans and New Health System expectations for regional population health improvement after the initially-proposed ten year period.

Applicants' Response:

In Section 8.A of the Application, the Applicants address the significant health care challenges that face the population of the geographic service area. As outlined on page 30, a 2015 Tennessee Department of Health report, *Drive Your County to the Top Ten*,³¹ found that:

- All Tennessee counties in the Geographic Service Area exceed the national average for smoking
- The state level obesity rate exceeds the national average, and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%).
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birthweight births and
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates.

³¹ "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: <https://www.tn.gov/health/topic/specialreports>

Table 8.1 on page 31 of the Application reports key statistics on the population in the counties within the Geographic Service Area, including metrics for obesity, smoking, childhood poverty, and death rates due to drug poisoning. Full County Health Rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached to the Application as Exhibit 8.1A and 8.1B. Table 8.1 is provided below for reference.

Table 8.1 from the COPA Application

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	43rd	19%	32%	23%	27%	16
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015.
Accessible at www.countyhealthrankings.org

The Applicants specifically addressed the health priorities of the State in the discussion of the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) on pages 31-35. As noted in the Application, these four health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions that are responsible for higher health care utilization.

The Applicants' discussion of the "Big Three Plus One" issues from the Application are included below for reference:

Physical Inactivity & Obesity

Obesity and physical inactivity are mutually reinforcing public health concerns. Tennessee's state level obesity rate exceeds the national average. While most of the Tennessee counties in the 21-county geographic service area have obesity rates lower than the state average, Hawkins and Sullivan Counties are exceptions at 35% and 33% respectively. All of the Tennessee counties in the geographic service area exceed the state average for physical inactivity (30%). Most notably, Unicoi County has a physical inactivity rate of 37.0% and Hancock County has a physical inactivity rate of 39.4%. Measures for Virginia counties in the service area reflect challenges as well.

Tobacco Abuse

The "2015 Drive Your County to the Top Ten" report³² published by the Tennessee Department of Health Division of Policy, Planning, and Assessment State Department of Health demonstrates that all of the Tennessee counties in the 21-county geographic service area exceed the national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking. In particular, Hancock County and Carter County are at the high end of the range with smoking rates that exceed 30%.

Substance Abuse

Substance abuse is a key priority of the Tennessee Department of Health and a significant concern in this region. Of the ten Tennessee counties in the geographic service area, nine exceed the state average in the number of deaths due to drug poisoning per 100,000 population. Of particular note is Hancock County, which has the highest drug poisoning mortality rate in the state. Addressing substance abuse is one of the highest priorities of the New Health System, with efforts to address the specific needs of this population as well as improve access to, and coordination of care at, healthcare facilities for substance abuse patients.

³² "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: <https://www.tn.gov/health/topic/specialreports>

Table 8.2 reports key statistics on the population in the counties in the 21-county area for the "Big Three +1" health issues, including metrics for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the County scores worse than the state average for that particular metric.

	Physical Inactivity Score ³³	Obesity ³⁴	Tobacco Abuse ³⁵	Substance Abuse Score ³⁶
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%		29%	22
Hamblen County	33%	30%	23%	27
Hancock County	39%	30%	40%	42
Hawkins County	35%	35%	26%	26
Johnson County	34%	31%	28%	11
Sullivan County	35%	33%	26%	17
Unicoi County	37%	30%	23%	24
Washington County	30%	31%	24%	17
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

* Red shading indicates that a County's score exceeds the state average.

³³ Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁴ Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁵ Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁶ Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

The Parties share the State's concern about these four significant health issues and are aware of the acute challenges present in this region. The Parties intend for these four issues to be key areas of focus within the scope of the current Community Input Work Groups, as well as included in the Advisory Groups that will work to define the health index for the geographic service area.

The Applicants acknowledge that the New Health System will be responsible for population health in the region for an indefinite period of time. As a result, the New Health System has proposed a plan for development of the Index of Public Advantage and Community Health Improvement that includes input from community stakeholders and the State as outlined in Section 11.j of the Application. Additionally, the Applicants have set forth a proposal for development of this Index in Table 11.7, which identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Applicants propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Applicants have identified specific Health Concerns that pose an important challenge and priority for health in this region that are aligned with health challenges and priorities identified by the states. The Applicants have also identified a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally. The Applicants have proposed a representative investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area. The relevant Accountability Mechanism the Applicants believe reflects the New Health System's performance related to the investment, intervention, or performance improvement is also identified for each Health Concern. The Applicants have proposed a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern, and finally, the Applicants have identified County level disparities for each Health Concern as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

The Applicants seek to engage the COPA Index Advisory Group and the State in the final determination of the measures to be included in the Health Index. The Applicants expect to be held accountable for the commitments outlined in the Application and believe it is the goal of all those involved that the population health of the Geographic Service Area will improve with the New Health System's commitment of substantial resources and improved coordination of new and existing health programs.

Observation #5 - Duplication of Services

As noted in the report, MSHA and WHS currently have "expensive duplications of costs" and plan to reduce duplications post-merger through delivery model integration and "job displacement."³⁷ Limited detail of these plans is provided.

The department also notes that most other hospital mergers (including the merger of St. Joseph's Hospital and Memorial Mission Hospital in 1995 supervised by the State of North Carolina through a COPA) result in the reduction of the number of full-time equivalent positions.

Department Position:

Pursuant to department rule, the application must include "economic metrics that detail anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement."³⁸

To ascertain how efficiencies in operating costs and shared services could potentially impact population health and health care, the department needs additional detail to evaluate the potential benefits and disadvantages of these plans to achieve these cost savings. Specifically, the department will require a good faith estimate of the number of full-time equivalent positions estimated to be eliminated each year, or if none, other plans to achieve stated efficiencies.

Applicants' Response

Section 11.i of the Application details the anticipated efficiencies in operating costs and shared services the Applicants expect to gain through the Cooperative Agreement. As noted on pages 81-82 of the Application, funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. The New Health System, by aligning Wellmont and Mountain State's individual efforts in key service areas, will be able to drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies to address this question in the Application. As detailed on pages 82-84 of the Application, the economies

³⁷ Wellmont Health System and Mountain States Health Alliance. Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report. January 2016. p. 8-9.

³⁸ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix).

analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are addressed in the Application on pages 82-83 and copied below for reference:

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include
 - Harmonization to a Common Clinical IT platform
 - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
 - Reductions in unnecessary duplication of Call Pay
 - Reductions in Locum Tenens and use of "Registry Staff"
 - Renegotiations of service, maintenance, and other contracts
 - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
 - Added economies and efficiencies gained from the larger size of the New Health System.

The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately \$70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions

within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from the merger in labor expenses totaling approximately \$25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. **Clinical Efficiencies.** The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most

effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

The Applicants wish to specifically address the Department's questions about workforce. As detailed on page 83, the Applicants are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Applicants do not anticipate any merger-related reductions in force that would trigger federal or state notification obligations. At this time, the Applicants believe that the workforce adjustments can primarily be handled through reassignment of duties and normal attrition.

Additionally, in Section 11.f, beginning on page 67 of the Application, the Applicants address the State's questions about the impact of the merger on the service area's health care industry workforce. The Applicants' expect to achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by patient volumes and varies across the market from time to time. The Applicants recognize that health care workers are in great demand in this particular region, and retaining and developing excellent health professionals in the region will be of utmost importance to the New Health System to ensure the highest clinical quality.

Observation #6 - Reinvestment of Cost Savings

The report does not state whether the estimated \$450 million re-investment of cost-savings is a conservative or optimistic projection. The report also does not allow the reader to discern the estimate of the intervals and amounts of savings and subsequent reinvestments planned over the proposed ten year period.

Department Position

To allow the department to evaluate this aspect of public benefit, the application should include a good faith estimate of the expected annual expenditures in each reinvestment category that will be realized each year.

Applicants' Response:

The Applicants addressed this objective in Section 11.i of the Application in the discussion of the anticipated efficiencies in operative costs and shared services the Applicants expect to gain through the Cooperative Agreement. Specifically, the Applicants would like to draw your attention to the following:

At the end of "Non-Labor Efficiencies" section on page 82, the Applicants state:

The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

At the end of the "Labor Efficiencies" section on pages 83-84, the Applicants state:

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the

community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

At the end of the "Clinical Efficiencies" section on page 84, the Applicants state:

The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

SECTION 2: DEPARTURE OF ALICE POPE, WELLMONT'S CHIEF FINANCIAL OFFICER

On March 8, 2016, Wellmont Health System announced that Alice Pope, the system's executive vice president and chief financial officer, will become the new chief financial officer for HonorHealth in Scottsdale, Arizona. Pope will continue serving in her Wellmont leadership position, which she has held for 3 ½ years, for the next 60 days and will assist in a smooth transition. She has worked for Wellmont for 16 years, steadily advancing to positions of increasing responsibility. The timing of Pope's announcement was, in part, to allow strategic decisions to be made for Wellmont and for the new health system that would result from the proposed merger of Wellmont and Mountain States Health Alliance if the Application is approved.

In the term sheet and applications for a Certificate of Public Advantage in Tennessee and cooperative agreement in Virginia, Pope was designated to serve as the proposed new health

system's chief financial officer. The chief financial officer position for the proposed new health system will be evaluated by both Applicants given Pope's departure and the Applicants will notify the Department of any decisions by the Applicants that may affect the executive leadership structure of the New Health System or the COPA Application. The change is not expected to impact the proposed merger itself.

SECTION 3: TECHNICAL CORRECTION TO SECTION 6 OF THE COPA APPLICATION AND ACCOMPANYING EXHIBITS

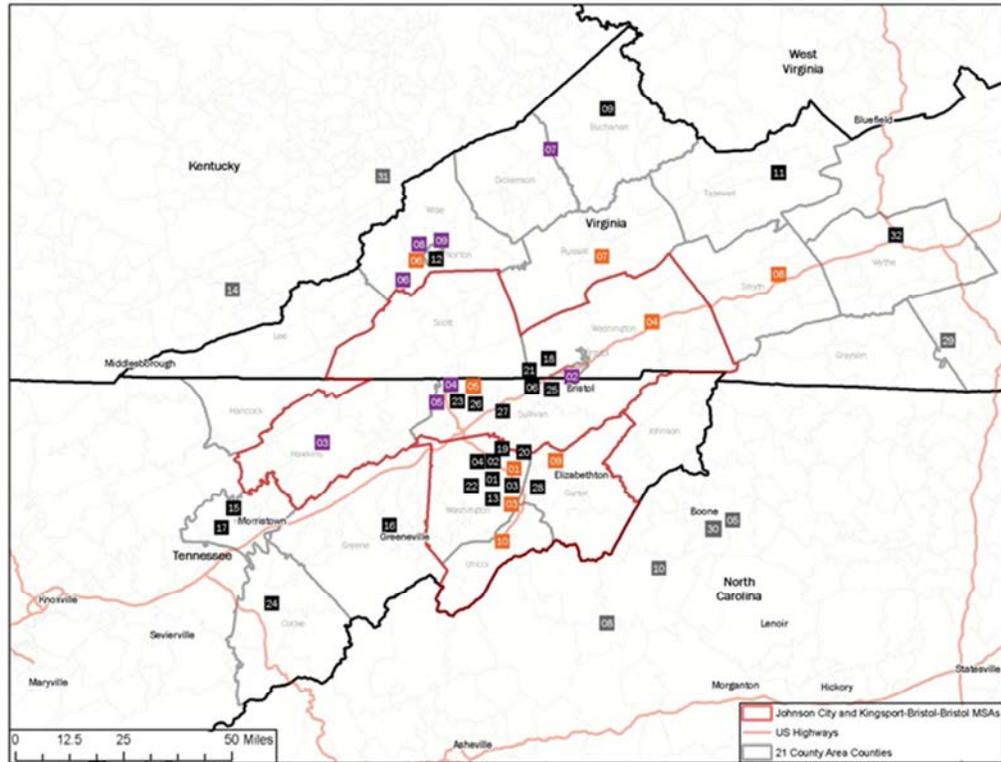
Section 6 of the Application and Exhibit 6.1D list the Ambulatory Surgical Center Locations and Counts, by System. Among the Ambulatory Surgical Center Locations listed in the Application is the State of Franklin OB/GYN, which is listed as performing surgery in an ASC setting. It has come to the Applicants' attention that the State of Franklin OB/GYN performs in-office surgical procedures but does not have an Ambulatory Surgical Center. To correct this oversight, the Applicants wish to remove the State of Franklin OB/GYN from the list of ASCs. This change will affect the following four sections of the Application:

1) Application Section 6 - pages 25-26

- Delete the following:

Wellmont and Mountain States each have ambulatory surgery centers ("ASCs")²⁴ in the area, but fifty-seven percent (57%) are competing facilities. The locations of all area ASCs are shown in Figure 6.3 below. Exhibit 6.1D lists all ASCs serving the Geographic Service Area.²⁵

Figure 6.3 – Map of Location of Ambulatory Surgical Centers²⁶



²⁴ ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

²⁵ The outpatient facilities listed in Exhibit 6.1D include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

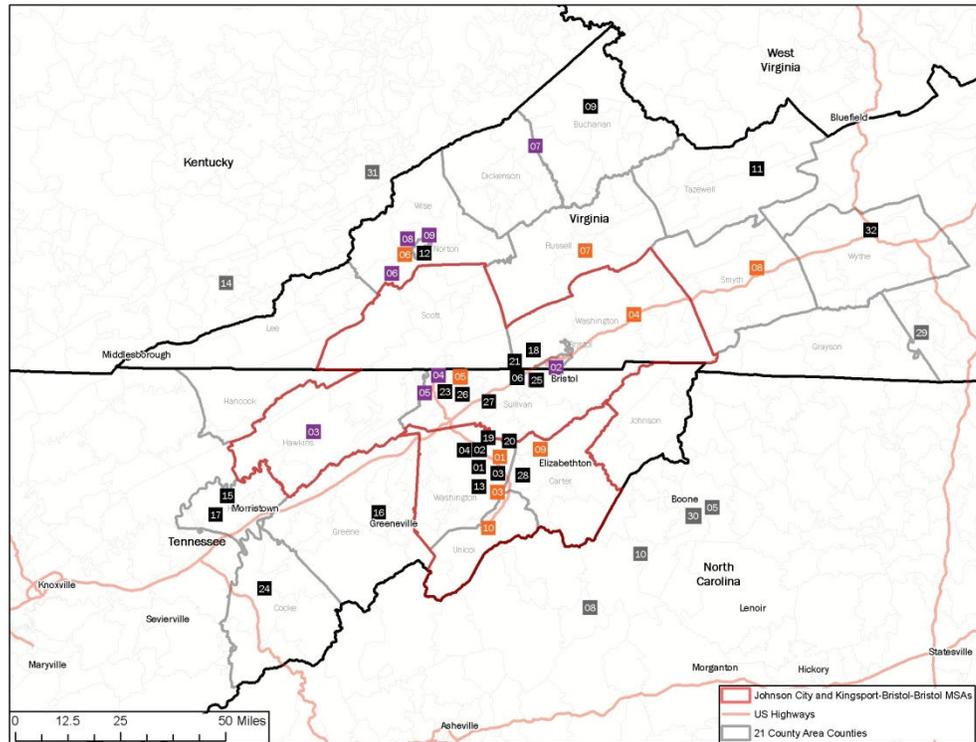
²⁶ An enlarged version of the map and the legend are attached as Exhibit 6.1D.

- Replace it with:

Wellmont and Mountain States each offer outpatient surgery services²⁴ in the area, but fifty-five percent (55%) of the outpatient surgical facilities in the area are operated by competitors of Wellmont and Mountain States. The locations of all area outpatient surgical facilities are shown in **Figure 6.3** below. **Table 11.5** and **Exhibit 6.1A** break out the count and share for each category of outpatient surgical facilities while **Exhibit 6.1D** lists all outpatient surgical facilities serving the Geographic Service Area.²⁵

Figure 6.3 – Map of Location of Outpatient Surgical Facilities²⁶

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Application for Certificate of Public Advantage
State of Tennessee



²⁴ Outpatient surgery services include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

²⁵ The outpatient surgical facilities listed in Exhibit 6.1D include the outpatient surgical facilities located in the Geographic Service Area and serving the Geographic Service Area.

²⁶ An enlarged version of the map and the legend are attached as Exhibit 6.1D.

2) Application Table 11.5

- Delete the following:

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS	Mountain States	Mountain States-	Non-Managed Joint		Total	
	Combined %		NsCH Affiliate	Wellmont	Venture All Other		
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	50.0%	2	0	3	4	9	18
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

- Replace it with:

TABLE 11.5 - SHARES OF OUTPATIENT FACILITIES BY SYSTEM

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States- NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

3) Application Exhibit 6.1 - Attachment A

- Delete the following:

A. All Outpatient Facilities

Service Type	WHS & MSHS	Mountain	Mountain	Non-	Non-		Total
	Combined	States	NsCH	Managed	Joint	All Other	
	%		Affiliate	Wellmont	Venture		
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	50.0%	2	0	3	4	9	18
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

- Replace it with:

A. All Outpatient Facilities

Service Type	WHS & MSHS	Mountain	Mountain	Non-	Non-		Total
	Combined %	States	States- NsCH Affiliate	Wellmont	Managed Joint	All Other*	
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
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Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

*All Other may include competing facilities located outside of the Geographic Service Area yet serving patients from the Geographic Service Area.

Ambulatory Surgical Centers Outpatient Facilities	
Wellmont	
01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Sugery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital (<i>Independent</i>)*
09	Wellmont Loesome Pine Hospital
10	Wellmont Mountain View Regional Medical
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
22	State of Frankin OB/GYN Specialists
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital
MSHA	
01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital
All Other Facilities	
01	East Tennessee Ambulatory Surgery Center, LLC**
02	Johnson City Eye Surgery Center**
03	Mountain Empire Surgery Center, LP**
04	TriCities Laser Center**
05	Appalachian Gastroenterology

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Non-Managed Joint Venture

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
Total	Total			17	31	30
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA			X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Lonesome Pine Hospital	Wise	VA		X	
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	Total			3	5	5
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	Total			2	9	9
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

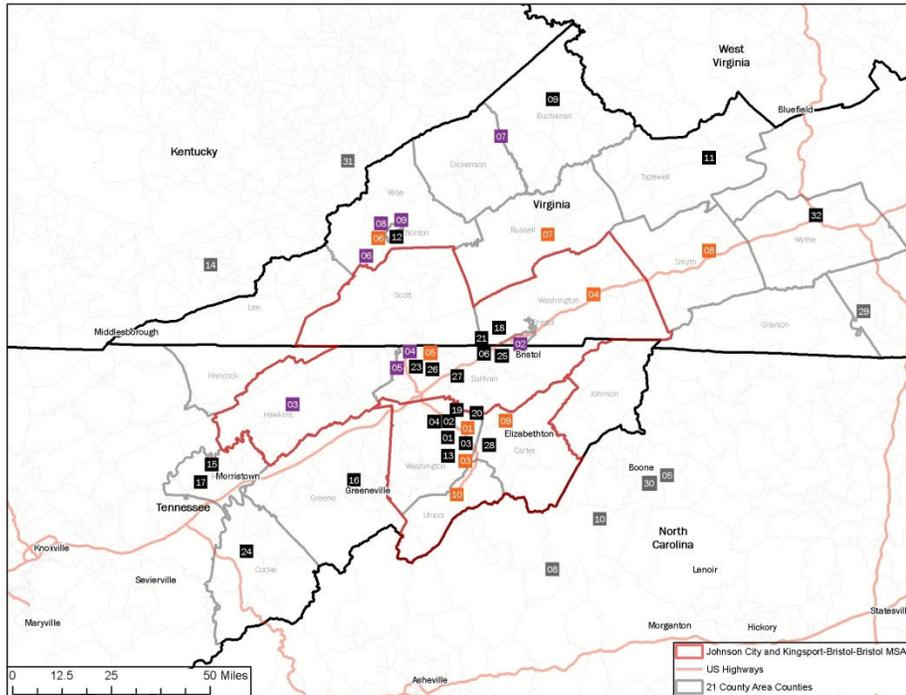
System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	Total			4	0	0
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Regional Surgical Services	Tazewell	VA	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	State of Franklin OB/GYN Specialists	Washington	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	Total			8	17	16

- Replace it with:

D. Outpatient Surgical Facilities*



* Outpatient Surgical Facilities include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities. These facilities are included in the map and table.

Outpatient Surgical Facilities	
Wellmont	
01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital (<i>Independent</i>)*
09	Wellmont Mountain View Regional Medical
MSHA	
01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center**
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital
All Other Facilities	
01	East Tennessee Ambulatory Surgery Center, LLC***
02	Johnson City Eye Surgery Center***
03	Mountain Empire Surgery Center, LP***
04	TriCities Laser Center***
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital (“Takoma”) to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Managed Joint Venture

*** Non-Managed Joint Venture

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	Total			15	31	30
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	Total			3	5	5
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center**	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	Total			2	9	9
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	Total			4	0	0
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	Total			6	17	16

** Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

SECTION 4: EXHIBITS 11.4 - ATTACHMENT D AND 11.4 - ATTACHMENT E

Certain exhibits were withheld from the Application because they contained competitively sensitive or confidential information of the Applicants. Among the exhibits withheld were Exhibit 11.4 - Attachment D - Mountain States Covenant Compliance Certificates for the Last Five Years and Exhibit 11.4 - Attachment E - Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14.

After further discussions with counsel, Mountain States has determined that these two exhibits (11.4 - Attachment D and 11.4 - Attachment E) should be filed publicly with the Department. The Applicants have attached these exhibits to this Addendum #1 for review by the Department.

The Applicants support the Department's commitment to transparency in reviewing the Application and will continue to work with counsel, the Department, and the Tennessee Attorney General's office to make all information required for the Application available to the Department while respecting federal antitrust laws.

**RESPONSES TO QUESTIONS
SUBMITTED APRIL 22, 2016
BY
TENNESSEE DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE**

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: July 13, 2016

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Exhibit 30

- Details Regarding Wellmont's Severance Packages

Exhibit 31

- Proposed Employment Agreements with New Health System

Exhibit 32

- Physician Needs Assessment from Niswonger Children's Hospital

Exhibit 33

- Audited Results for FY2011 to FY 2015

Exhibit 34

- Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 35

- Updated Financial Model

**RESPONSES TO QUESTIONS
SUBMITTED APRIL 22, 2016
BY
TENNESSEE DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE**

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: July 13, 2016

Additional Request from the Department of Health
Submitted April 22, 2016

Mountain States Health Alliance and Wellmont Health System Response

I. INCOMPLETE (1)

a. Services Offered by Other Providers

Tenn. Comp. R. & Regs. 1200-38-01-. 02(2)(a)8

Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:

i. Limit services and products provided to those within the geographic service area;¹

RESPONSE: The Parties have attached the information requested above as Exhibit 1, which shows the hospitals providing inpatient services to residents of the Geographic Service Area, and limits the hospitals to only those physically located within the Geographic Service Area. The Parties have several concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the assessment of alternatives and competitive constraints on the Parties. These alternatives are relatively large in number and include major academic medical centers (AMCs) offering an array of services, including more advanced tertiary and quaternary services, specialty hospitals (such as psychiatric facilities), and community hospitals located in adjacent areas. These provide alternatives for commercially insured and other patients. There is clear evidence of market share overlap in these areas despite the existence of state or other political borders. Wellmont and Mountain States believe that the relevant competitive impact coming from organizations physically located outside the proposed 21-county Geographic Service Area is small. However, to the extent it is measurable, the Parties believe it is more accurate to include all competitive impact when analyzing competition within and the effect of the proposed transaction in the proposed 21-county Geographic Service Area. We respectfully suggest that, while exclusion of out-of-area competitors may be one interpretation of the rule, evaluation of post-merger effects should take into consideration responses to any alleged anticompetitive pricing and any repositioning that hospitals and payers may undertake, which would tend to start with identification of those additional competitors. As a result, the Parties respectfully request that the services and product information contained in their original Application dated February 16, 2016 be included in the record so that it is available for analysis.

¹ Pursuant to department rule, identification of services offered by other providers and the corresponding market share calculations should be limited to the geographic service area identified in the application. The application identifies the geographic service area (GSA) as a 21 -county area that includes ten (10) Tennessee and eleven (11) Virginia counties. In contrast, Application Section 6, Exhibit 6, and Addendum #1 Section 3 include products from competitors located outside this 21-county GSA.

INDEX OF DOCUMENTS:

- Exhibit 1 - Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area
- ii. **Revise classification of facilities to reflect substitutable services or products;**²

RESPONSE: Outpatient facility listings have been revised to exclude five facilities. We have attempted to identify any center that expressly limits services and have considered the examples provided. We note that many ASCs have the ability to expand operations beyond current services by bringing on additional physicians/surgeons, and that overly narrow service lines may overstate competitive issues. A revised list of facilities to reflect substitutable services or products is attached as Exhibit 2.

INDEX OF DOCUMENTS:

- Exhibit 2 - Revised Classification of Facilities to Reflect Substitutable Services or Products
- iii. **Provide information on the structure of physician practices to calculate the appropriate market share.**³

RESPONSE: The Parties are calculating the appropriate market share for physician practices as requested and will provide this information to the Department as soon as possible.

INDEX OF DOCUMENTS:

- Exhibit 3 - Information on the Structure of Physician Practices (to be provided in a subsequent response)
- iv. **Identify physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant.**

RESPONSE: The list of physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant will be provided under CID to the Attorney General's Office.

² A facility is the method of delivery for the product but is not necessarily itself the product. For example, gastroenterology, orthopedic, and eye surgery centers are not substitutable (i.e., a patient with eye issues would not consider accessing the former two surgery centers). Consequently, these facilities cannot be listed under the same product or used to calculate a market share.

³ The market power of a single physician is not equal to the bargaining power of a physician group. Therefore, in Exhibit 6.1-E, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required.

INDEX OF DOCUMENTS:

- Exhibit 4 - Physicians Under an Exclusive Contract (considered confidential information and will be subsequently filed)

b. Description of the Competitive Environment

Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (v)

Recalculate market shares using appropriate geographic market and output measures.⁴

RESPONSE: The Parties have attached the information requested above as Exhibit 5, which presents shares based on discharges in the Geographic Service Area. As noted above in Section I(a)(i), the Parties have concerns about excluding competitors not physically located in the proposed 21-county Geographic Service Area from the evaluation of competition and from share measures. These competitors represent alternatives for payers, patients, and their physicians; the data and information show that physicians are referring patients for a large array of services out of the Geographic Service Area to several hospitals, including the leading AMCs and hospitals in Tennessee and Virginia for commercially insured and other payers. These alternatives are very relevant to evaluation of the transaction; retaining and regaining volumes locally with an enhanced integrated delivery network and improved care models are important goals of the proposed transaction. To accomplish this, the Parties will have every incentive to improve quality and deliver care in cost-effective and high value fashion. As a result, the Parties respectfully request that the market share information contained in the original Application dated February 16, 2016 be included in the record so that it is available for analysis.

INDEX OF DOCUMENTS:

- Exhibit 5 - Recalculation of Market Shares

c. Cooperative Agreement - EXHIBIT 11.1

Tenn. Comp. R. & Regs. 1200-38-01-. 02(2) (a) J 3

- i. **Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.**

RESPONSE: A copy of the nonbinding April 2, 2015 Term Sheet is attached as Exhibit 6.

INDEX OF DOCUMENTS:

⁴ See Incomplete Item I.a.

- Exhibit 6 - Copy of the Nonbinding April 2, 2015 Term Sheet
- ii. **Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:**

1. **Exhibit C-1: Interim Parent Company Articles and Interim Parent Company Bylaws.**

RESPONSE: The Interim Parent Company Articles are attached as Exhibit 7. The Interim Parent Company Bylaws are attached as Exhibit 8.

INDEX OF DOCUMENTS:

- Exhibit 7 - Interim Parent Company Articles
- Exhibit 8 - Interim Parent Company Bylaws

2. **Exhibit C-3: Amended Parent Company Articles.**

RESPONSE: The Amended Parent Company Articles will not be adopted until at or shortly before the closing. The only two changes that will be made to the current Interim Parent Company Articles are (1) to change the principal place of business to the office location selected by the Parties and (2) to change the name from "Newco" to the permanent name selected by the Parties.

3. **Exhibit C-4: Amended Parent Company Bylaws.**

RESPONSE: The Amended Parent Company Bylaws will not be adopted until at or shortly before the closing. A draft of the Amended Parent Company Bylaws is attached as Exhibit 9.

INDEX OF DOCUMENTS:

- Exhibit 9 - Amended Parent Company Bylaws

II. **INCOMPLETE (2)**

a. **Potential Disadvantages**

Tenn. Comp. R. & Reg. 1200-38-01-.02(2) (a)3 (iv)

Identify any potential disadvantages that may result from the Cooperative Agreement.

RESPONSE: A detailed explanation of any potential disadvantages that may result from the Cooperative Agreement and how the Parties have proposed to address these potential disadvantages is attached as Exhibit 10. The Parties have also included an explanation of each of the likely benefits resulting from the agreement to be weighed against the potential disadvantages. By way of overview, we note that the agreement

provides a unique opportunity to create a fully integrated patient-centric healthcare delivery network with common infrastructure supporting technologies and care models, coordinated care, and needed investments in population health in the largely rural communities characteristic of the Geographic Service Area. These represent advantages and consumer and community benefits that are unlikely to occur absent this transaction.

INDEX OF DOCUMENTS:

- Exhibit 10 - Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

b. Geographic Service Area

Tenn. Comp. R. & Regs. 1200-38-01-. 02(2)(a) 7

Detail whether the New Health System intends to increase its market share in the following counties: Harlan and Letcher in Kentucky; and Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

RESPONSE: The New Health System does not intend to increase its market share in Harlan and Letcher in Kentucky; or Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

c. Insurance Contracts / Proposed use of any Cost Savings to Reduce Prices Borne by Insurers and Consumers ⁵

Tenn. Comp. R. & Regs. 1200-38-01-.02(2) (a) 13 (vii) (111)1 II

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(ix)(I)

- i. **Provide the number of current insurance contracts that represent less than 2% of patient services revenue.**

RESPONSE: Wellmont has sixty-eight current insurance contracts that each represent less than 2% of patient services revenue. A list of these sixty-eight insurance contracts (in alphabetical order) is provided as Exhibit 11.

Mountain States has one hundred sixty-one current insurance contracts that each represent less than 2% of patient services revenue. A list of these one hundred sixty-one insurance contracts (in alphabetical order) is provided as Exhibit 12.

INDEX OF DOCUMENTS:

- Exhibit 11 - List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue
- Exhibit 12 - List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

⁵ See Application pp. 46 and 47.

- ii. **Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system.**

RESPONSE: The Parties are not aware of any insurer that is active in the area that would represent less than 2% of patient services revenue and does not currently contract with either system.

- iii. **Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currently planned fixed rate increases. You may aggregate these rates separately for MSHA and Wellmont if you include the mean and standard deviation of the planned fixed rates.**

RESPONSE: Less than six percent of Mountain States' current insurance contracts have fixed rate increases as written. Sixteen percent of Wellmont's current insurance contracts have fixed rate increases as written.

The amounts and timing of Wellmont's and Mountain States' respective currently planned fixed rate increases will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 13 - Mountain States' Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)
- Exhibit 14 - Wellmont's Currently Planned Fixed Rate Increases (considered confidential information and will be subsequently filed)

- iv. **Provide the negotiated rate increases for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician or non-hospital outpatient services by more than the hospital or medical care Consumer Price Index minus 0.25%.**

RESPONSE:

The negotiated rate increases for the past five years calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician, or non-hospital outpatient services will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 15 - Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential)

information and will be subsequently filed)

- Exhibit 16 - Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services (considered confidential information and will be subsequently filed)

v. **Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.**

RESPONSE: For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%.

For example, if the current multi-year managed care contract between Wellmont or Mountain States and the payer included an automatic annual Inflater of 4% and Medical CPI was 3%, the New Health System's rate cap would then reduce that inflator to 2.75% (25 basis points less than Medical CPI). This provision will automatically apply to all current contracts that remain in force as well.

The Parties have proposed that this provision only apply to contracts with negotiated rates and should not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, the Parties have proposed that baseline rates or estimated reimbursement for inpatient and outpatient services for an expiring contract at the point of its expiration be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes for subsequent years.

Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of a natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index.

Following approval of the COPA, if the New Health System and a Principal Payer⁶ are unable to reach agreement on a negotiated rate, the New Health System agrees to mediation as a process to resolve any disputes.

⁶ The Application defines "Principal Payers" as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

The Parties anticipate that the cap on negotiated rates will be of substantial benefit to payers, employers, and consumers. With high-deductible health plans growing in popularity, and with the consumer bearing more of the financial responsibility for the cost of their care, the consumer's out-of-pocket payments will benefit from the use of these rate caps.

It should be noted that payers and employers determine all of the health plan designs, which result in how much out-of-pocket costs the consumers ultimately bear. The New Health System has no role or control over the establishment of how much the out-of-pocket costs are and will not even know what an individual patient's financial responsibility is until the service has been delivered and the claim has been adjudicated by the payer. With a high-deductible plan, the patient may owe essentially all of the contracted rate for services early in their plan year, but may owe nothing for the same services later in their plan year once the patient has already met their annual high deductible.

As high-deductible plans have become increasingly common, both Parties have seen an increase in the percentage of payments paid by individual patients versus payers. This trend has negatively impacted collection rates for both Parties which in turn has led to increases in charity care and bad debt. The New Health System has no control over the amount owed by individual patients under each individual health plan and, by law, is prohibited from waiving the co-pays and deductible amounts an individual may owe based on their plan design.

vi. **Detail how the New Health System will handle price setting for uninsured or private pay patients.**

RESPONSE: The New Health System will continue to treat all patients with dignity, compassion, and high-quality care standards regardless of their social status or ability to pay. The New Health System's charity care policy will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The policy will be published, and all patients will be advised of their ability to access services under the policy. The policy will apply at the time of service delivery rather than after collection attempts have been made. Patients will have no barriers to receiving needed care. The New Health System will place no dollar limits on the amount of charity care it will provide and commits to providing a charity care policy that incorporates the best elements of the current policies of each Applicant. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Applicants currently provide. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the

Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible. It is the goal of the New Health System to provide services to members of the community in a manner that is compassionate, fair, and reasonable and that does not result in an undue financial burden.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.

For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments.

d. Common Clinical IT and Health Information Exchange

Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a) 10

- i. **Provide your anticipated 10-year timeline with milestones for development and implementation for both the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. At a minimum, the timeline should include targeted objectives for each year following the formation of the New Health System, including target dates for the following activities:**
- 1. Behavioral health capability. If your chosen Clinical IT system does not currently include a behavioral health module, detail your plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors.**
 - 2. Integration of systems and / or linkage of records (medical, lab, pharmacy, diagnostic, and referral / scheduling).**
 - 3. Migration and / or archiving of pre-existing records.**
 - 4. Training for new users (System and non-System providers).**
 - 5. Patient access to information.**
 - 6. Capabilities for collecting, analyzing and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers (System and non-System).**

RESPONSE: If the COPA is approved, the Parties expect the New Health System to assess each party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application. This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as Exhibit 17 for reference.

INDEX OF DOCUMENTS:

Exhibit 17 - Anticipated 10-Year Timeline

- ii. **Provide estimates for how and when the \$150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for**

non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

RESPONSE: The estimates for how and when the \$150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities is attached as Exhibit 18.

INDEX OF DOCUMENTS:

- Exhibit 18 - Estimates for How and When the \$150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

- iii. **Describe the current commitment and timeframe for participation of both MSHA and Wellmont in OnePartner, the operational regional health information exchange. Also describe the options and plans for future participation (e.g., continued participation or acquisition of OnePartner, participation with a competing HIE provider, or development of a competing service offering).**

RESPONSE: A description of both Parties' use of health information exchanges ("HIEs") with information showing the current system used by each party, including current usage, how information is shared, fees or costs paid to use the system and the number of other providers currently using the system, how the records are shared, and the extent of patient records included in the exchange is attached as Exhibit 19.

Both Wellmont and Mountain States are currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange, however, specific details about which health information exchange the New Health System will participate in have not been decided at this time.

INDEX OF DOCUMENTS:

- Exhibit 19 - Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

- e. **Total Cost Resulting from Cooperative Agreement**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a) 15

Provide the total amount detailed in the reports from MSHA and Wellmont, referenced in the Master Affiliation Agreement Section 10.04(d), setting forth all Expenses incurred by the parties. Include justification for the above amount. Detail all additional merger-related expenses, including capital costs and management costs.

Provide documentation of the availability of the necessary funds.

RESPONSE: The Parties' combined expenses associated with the Cooperative Agreement are set forth below. The Parties have not incurred any capital costs related to the merger. The management, staff and board members of both Parties have spent thousands of hours working on the potential merger, but this time is not accounted for separately. All expenses related to the merger are paid on a monthly basis.

Expense Category	Expense Incurred as of June 15, 2016
Communication Services	\$1,129,408
Consulting Services	\$2,260,548
COPA Fees*	\$104,958
Due Diligence Services	\$2,497,435
Legal Services	\$10,496,155

* COPA Services include the filing fees and expenses that have been paid to the Southwest Virginia Health Authority and the Tennessee Department of Health.

f. **Description of Financial Performance**

Tenn. Comp. R. & Regs. 1200-30-01-02(2)(a) 13(vii)

i. **The description and summary of financial performance of Wellmont and MSHA does not adequately detail all components noted by department rule.**

RESPONSE: Application Exhibits 11.4 Attachments D and E were submitted in Addendum #1 to the COPA Application on March 17, 2016. Exhibit 11.5 Attachment D was submitted by Wellmont to the Attorney General's Office under CID on May 12, 2016.

ii. **Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the \$75 million investment in population health improvements; 2) the \$140 million to expand mental health, addiction recovery, substance abuse prevention programs; and 3) the \$85 million to develop and grow academic and research opportunities.⁷**

RESPONSE: As explained in the Application, the Parties have committed to reinvesting savings over the next ten years in the following categories:

- \$75 million towards population health improvements
- \$140 million towards the expansion of needed services which includes:
 - \$85 million for mental health and addiction recovery
 - \$27 million for pediatric sub-specialty access
 - \$28 million for rural health access; and
- \$85 million to develop and grow academic and research

⁷ Requests for additional detail regarding the \$150 million investment in Common Clinical IT and a Health Information Exchange are detailed in Incomplete Section II.d.

opportunities.

Additional detail on the activities to be funded by the proposed community reinvestment is attached as Exhibit 20.

INDEX OF DOCUMENTS:

- Exhibit 20 - Additional Detail on the Proposed Community Reinvestment

iii. **Complete the "Year-by-Year Summary" that requests an estimate of the year-by-year timing of reinvestments and cost savings. (See Attachment 1)**

RESPONSE: The New Health System commits to using reinvestments and cost savings to implement programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22.

INDEX OF DOCUMENTS:

- Exhibit 21 - Template Community Health Improvement Plan
- Exhibit 22 - Year-by-Year Summary

iv. **Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on your most recent IRS Form 990 Schedule H.⁸**

RESPONSE: Below are the net expenditures on community health improvement, health professions education, and research for Mountain States and Wellmont based on each organization's 2015 IRS Form 990 Schedule H.

	Mountain States	Wellmont
Community Health Education and Outreach	\$4,113,567	\$5,761,249
Health Professions Education	\$9,276,052	\$5,748,416
Research	\$237,449	\$140,715

v. **Detail whether a \$75 million investment in population health over ten years represents an increase in spending over that of past community health**

⁸ As non-profit hospitals, MSHA and Wellmont already provide some level of community benefit. The department notes that in 2012 MSHA and Wellmont had net expenditures of \$10.8 million on community health improvement and \$18.9 million on health professions education and research.

investment, and if so, provide an estimate of the aggregate planned population health investment.

RESPONSE: Should the COPA be granted, the investment in population health set forth in the Application represents a net increase of \$75 million in aggregate over that of past community health investment for the ten year period following the creation of the New Health System.

- vi. **Detail whether an \$85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.**

RESPONSE: Should the COPA be granted, the investment in research and training set forth in the application represents a net increase of \$85 million in aggregate over the past research and training investment for the ten year period following the creation of the New Health System.

- vii. **Compare and contrast the type of programs currently funded by Community Benefit spending, particularly in the categories above, with the planned investment over the next ten years.**

RESPONSE: The Community Benefit spending reported in the Parties' IRS Form 990s and annual reports represent investments in social responsibility efforts which are outside of their clinical core functions. The financial value of the Parties' current Community Benefit spending will serve as a baseline for the new incremental investments the Parties have proposed under the COPA, subject to adjustment for the most current financial performance of the combined systems to ensure the community benefit spending reflects current market conditions.

The Parties' current Community Benefit spending also represents the substantial investments made by our health systems to provide charity care to those in need or to fund uncollectable payments for medical services. It includes investments made by each health system and their respective foundations to improve the delivery of health care and quality of life in the region. This includes providing financial support to outside organizations whose work aligns with the Parties' efforts to improve the overall health status and economic vitality of the region. As explained in the Application, the Parties' plans for incremental investments under the COPA may increase support for certain current efforts as well as fund new efforts.

The Parties' current Community Benefit spending includes investments in graduate medical education, including residency slots and the internal infrastructure required to support them. The current Community Benefit spending also includes investments in direct support for health professions training along with internships and preceptor work associated with allied health professional training. At any given point, the two health systems are serving

one thousand plus students collectively and supporting their ability to learn in the clinical environment. Again, the investments the Parties plan to make as a part of the COPA will be over and above these current levels of Community Benefit.

In addition to workforce education and training, the Parties currently support many regional efforts to improve community health. Examples of this work include programs sponsored by the two health systems, such as the Mountain States' Morning Mile walking program for area children and Wellmont's Project Fit America program to provide outdoor exercise play equipment and curriculum to schools. Both organizations also support third-party efforts such as Healthy Kingsport, regional YMCA/YWCA programs, Girls and Boys Clubs, and many more organizations and programs which are designed to be catalysts for health improvement. Once the community health improvement goals are agreed upon with the state, the Parties will work collaboratively with local stakeholders to leverage existing programs that are operating successfully and support the establishment of new programs where gaps exist.

By the third year, the reinvestments in community benefit funded through the efficiencies gained by the proposed merger will double the current level of community benefit spending of the Parties as outlined in their most recent 990s and will approach a consistent rate of at least 2.5 times the current level by year five. This increase in community benefit spending will be in addition to the substantial financial support the New Health System will offer patients through the provision of charity care and self-pay discounts.

viii. **Provide the audited financial statement on MSHA as of June 30, 2015. (See Exhibits 11.4-F)**

RESPONSE: The audited financial statement on MSHA as of June 30, 2015 is attached as Exhibit 23.

INDEX OF DOCUMENTS:

- Exhibit 23 - Audited Financial Statement on MSHA as of June 30, 2015

ix. **On April 06, 2015, Fitch Ratings placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of Johnson City, TN, revenue bonds issued on behalf of MSHA and parity debt issued on behalf of MSHA listed in April 06, 2015 press release. Provide the current status regarding Fitch's Rating Watch. (See Exhibits 11.4-H)**

RESPONSE: Mountain State's current Fitch Ratings Watch is attached as Exhibit 24.

INDEX OF DOCUMENTS:

- Exhibit 24 - Mountain State's current Fitch Ratings Watch

g. Efficiencies in Operating Costs and Shared Savings

Tenn. Comp. R. & Regs. 1200-30-01-. 02 (a) 13(ix)

Provide the report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger.

RESPONSE: The report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 25 - FTI Consulting Report (considered confidential information and will be subsequently filed)

III. GENERAL COMMENTS

- a. **Detail how an additional layer of governance (i.e., the parent company) benefits the organization.**

RESPONSE: The creation of the New Health System as the sole member, and essentially the “holding company”, of the currently existing corporations of Wellmont and Mountain States is critical to preserving the cash flow of the combined entity. If the Parties were to merge one of the existing corporations (Wellmont Health System/Mountain States Health Alliance) into the other, that would be considered a change of ownership by the Centers for Medicare and Medicaid Services (“CMS”).

A change of ownership requires that CMS issue new provider numbers. The process of applying for and receiving new provider numbers takes between three and six months, during which time CMS will not pay for services rendered at the hospitals undergoing a change in ownership. Approximately one-half (1/2) to two-thirds (2/3) of the cash flow from the involved hospitals would be withheld during this three to six month period of time due to the level of government-paid patient volumes seen at those hospitals. While CMS will ultimately pay for such services after new provider numbers are issued, the interruption of such a significant amount of the cash flow for the New Health System would be crippling. By putting the New Health System in place, the merger is not considered a change of ownership by CMS, thereby avoiding a debilitating cash-flow interruption. Primary governance functions of the New Health System will account for the majority of all governance activities since the New Health System will become the sole member of the existing Wellmont and Mountain States entities. The current organizations will limit governance to those essential functions that need to be retained for basic corporate oversight. Thus, the new structure will not create any significant redundancy of governance functions.

- b. **Provide an organizational chart that shows the resulting institution.**

RESPONSE: Exhibit 26 includes an organizational chart that shows the resulting New Health System.

INDEX OF DOCUMENTS:

- Exhibit 26 - Organizational Chart

- c. **Clarify the amount of current debt and what is proposed in debt repayment and/or incurring additional debt as a result of this proposal.**

RESPONSE: Exhibit 27 shows the current debt for Mountain States as of third quarter FY2016. Exhibit 28 shows the current debt for Wellmont as of third quarter of FY2016. The assumption on debt repayment in the FTI model is: the repayment schedules for both organizations will remain the same. However, the Parties currently project, based on current market conditions, that significant savings opportunities exist for restructuring debt. The savings have not been incorporated into the model because the Parties cannot accurately predict the amount of savings that could be achieved at the time the transaction closes.

The FTI model assumes that NewCo will not incur any additional debt as a result of the transaction.

INDEX OF DOCUMENTS:

- Exhibit 27 - Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio
- Exhibit 28 - Wellmont's Third Quarter FY2016 Financial Statements

- d. **Provide details regarding severance packages, including but not limited to, timing of implementation and dollar amount. Include details of severance packages currently being paid. (See Application p. 61)**

RESPONSE: Details regarding each Party's severance packages will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 29 - Details Regarding Mountain States' Severance Packages (considered confidential information and will be subsequently filed)
- Exhibit 30 - Details Regarding Wellmont's Severance Packages (considered confidential information and will be subsequently filed)

- e. **Provide proposed employment agreements mentioned in the application.**

RESPONSE: The proposed employment agreements mentioned in the Application will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

- Exhibit 31 - Proposed Employment Agreements with New Health System

(considered confidential information and will be subsequently filed)

- f. **Describe the proposed performance parameters that will be used to measure employee performance.**

RESPONSE: The New Health System will implement a set of performance standards that incentivize all team members to pursue objectives to increase clinical quality, improve the patient experience, and achieve the financial goals of the New Health System. These parameters will be established based on annual goals which will be approved by the governing board once the New Health System is established. These parameters will be communicated clearly and proactively to team members. Overall performance will also be evaluated against the efforts of individual employees to contribute to the achievement of the New Health System's mission, vision, and values.

- g. **The resulting board appears to be comprised of nine (9) members, of which only eight (8) will be voting members. Identify and/or detail how the board would deal with a 4/4 vote.**

RESPONSE: As noted in the Application,⁹ the New Health System will be governed exclusively by its board of directors, which is the fiduciary board responsible for the delivery of quality care in consideration of the needs of the communities served by the system. The board of directors of the New Health System will be composed of fourteen (14) voting members, as well as two (2) ex-officio voting members and one ex-officio non-voting member.

Wellmont and Mountain States will each designate six (6) members to serve on the initial board of directors of the New Health System. In addition, Wellmont and Mountain States will jointly select two (2) members of the initial New Health System board, who will not be incumbent members of either Party's board of directors. The two (2) ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The sole ex-officio non-voting member will be the then-current President of ETSU.

Pursuant to the Bylaws of the New Health System, to be approved, actions of the Board of Directors require the affirmative vote of at least a majority of the voting directors at a meeting at which a quorum is present. Therefore, tie votes would result in disapproval of the motion under consideration by the board.

- h. **Provide the Physician Needs Assessment from Niswonger Children's Hospital and detail how recruitment strategy will differ post-merger.**

RESPONSE: The Physician Needs Assessment for Niswonger Children's Hospital will be provided under CID to the Attorney General's Office.

INDEX OF DOCUMENTS:

⁹ See Application Section 11(b).

- Exhibit 32 - Physician needs Assessment from Niswonger Children's Hospital (considered confidential information and will be subsequently filed)

IV. INCONSISTENCIES

The applicants should address the inconsistencies noted below.

<p>Exhibit 11.4, pages 3 and 5 (Adobe pgs. 709 and 711/2578)</p>	<p>The Statement of Operations summary for the fiscal year ended June 30, 2014 did not always appear to agree with amounts presented on the financial statement included in the application (Exhibit 11.4, Attachment F). For example, the summary reported net patient revenue decreased by \$3.8 million; however, the audited financial statement (Adobe pg. 1538/2578) reflected a decrease of \$4.96 million. Additionally, the Balance Sheet summary for the fiscal year ended June 30, 2014 stated that part of the reason for the increase in assets was due to an increase in patient receivables; however, the Consolidated Balance Sheet (page 1536/2578) reflected a decrease in patient accounts receivable of approximately \$3 million from the prior year.</p>
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RESPONSE: Internal financial packages were used to provide the calculations in the summary provided in the Application. Mountain States has attached calculations to demonstrate the variances in the REVISED summary (attached). All changes have been bolded. The variance between the internal financials and audited financials and explanations for the changes in the summary are:

- A. The internal financials do not have eliminations for Mountain States' employee health plan. These eliminations (1) reduce net revenue and (2) reduce benefit expense. The benefit eliminations are included in the audited financials. The summary has been revised to include the benefit eliminations amounts.
- B. The internal financial package includes incentive pay as a non-operating expense. The audited financials classify incentive pay in salaries and wages. The summary reflects incentive pay in non-operating expenses.
- C. The FY2012 internal financial package includes the loss on early extinguishment of debt as a non-operating expense. The audited financials classify the loss as an expense in the prior year in the new audited format for FY2013. The summary reflects the loss on extinguishment as non-operating and the loss on extinguishment is therefore excluded from the income from operations calculation.
- D. The FY2015 audited financials include an elimination for Mountain State's owned Medicare Advantage insurance plan. These eliminations (1) reduce net revenue and (2) reduce medical cost. This elimination was not done in FY2014. The FY2014 audited financials have been revised to be comparable. The summary has been revised to reflect these benefit eliminations.

The summary was written before Mountain State's final FY2015 audited financials were

issued. Therefore, the summary was based on preliminary unaudited results. The summary has been updated to reflect the final audited results for FY2015.

From time to time, items may be reclassified in Mountain States' audited financial statements. When comparing prior years, the numbers may not match exactly due to the reclassifications. These reclassifications are completed in order to make the financial statements comparable.

For example, in FY2012, per new accounting guidance, bad debt expense was included as a deduction from net revenue. Also, revenue associated with Mediserve Durable Medical Equipment was classified as Other Revenue instead of Patient Revenue. The FY2011 audited financials were revised to be consistent with the new FY2012 classification. The summary has been revised to reflect these changes. The FY2012 comparison is based on the FY2012 audited financial as compared to the FY2011 audited financial adjusted for the bad debt expense and durable medical equipment revenue reclassifications.

In FY2013, the format of Mountain States' audited financial was changed. There is no differentiation between operating and non-operating revenue and expenses. The audited results for FY2013 to FY2015 are attached as Exhibit 33 in a comparable format that was used for FY2011 and FY2012.

INDEX OF DOCUMENTS:

- Exhibit 33 - Audited Results for FY2011 to FY2015

Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015 and Material Event Disclosures (as listed on page 126) (Adobe pg. 128/2578)	The exhibit was not included in the application. This exhibit was not included in the list of excluded information on page 119; therefore, it appears to have been omitted from the application in error.
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RESPONSE: Exhibit 11.5 - Attachment C was inadvertently omitted from the Application. It is attached to this response as Exhibit 34.

INDEX OF DOCUMENTS:

- Exhibit 34 - Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 11.8, page 2 (Adobe pg. 2500/2578)	<p>The "Timing and Phases of Efficiency Assumptions" section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE 6/17; however, the "Preliminary Efficiencies" Model Income Statement appeared to reflect savings of \$41,144 over the "Baseline" model for the FYE 6/16 (i.e., savings of \$21,632 in medical supplies and drugs, \$5,651 in purchased services, \$1,002 in maintenance and utilities, and \$12,859 in other).</p>
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RESPONSE: The "Timing and Phases of Efficiency Assumptions" description included savings that could be negotiated on day one. Since these contract changes would occur at the start of the merger FTI assumed the impact would be immediate. In the "Baseline" model, FTI has updated the timing in the second run of the model to start FYE 6/17 which reflects the current anticipated timeline. The updated Financial Model is attached as [Exhibit 35](#).

INDEX OF DOCUMENTS:

- [Exhibit 35](#) - Updated Financial Model

Exhibit 11.8, page 9 (Adobe pg. 2507/2578)	<p>It appears, for the forecasted columns of the "Baseline" Model Balance Sheet, total net assets should equal the prior year ending net assets balance plus revenues in excess of expenses reported on the operating statement on the previous page. However, the total net assets balances reported on the "Baseline" Model Balance Sheet in the 2016 through 2020 columns did not equal this. The difference appears to be related to the income attributable to non-controlling interests.</p>
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RESPONSE: For the forecasted columns of the "Baseline" Model Balance Sheet, the assumptions in the baseline were that the Company post-merger would have to payout each Joint Venture entity's interest, while currently the separate hospitals do not appear to make those distributions and allow each Joint Venture entity to maintain the cash balance. The total net asset balances reported in the Baseline Model Balance Sheet in the 2016 through 2020 columns have been updated to match the baseline assumption, that the Joint Venture entities do not make distributions and retain the cash. See attached [Exhibit 35](#).

Exhibit 11.8, pages 12 and 13 (Adobe pgs. 2510-11/2578)	<p>On the "Preliminary Efficiencies" Model Cash Flows, the cash flows from financing activities included amounts for each year for payments made related to income attributable to non-controlling interest. However, it appears the "Preliminary Efficiencies" Model Balance Sheet on the previous page reflected this amount as part of net assets each year (i.e., the non-controlling interest component of net assets increased each year by the amount of income attributable to non- controlling interest).</p>
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RESPONSE: See explanation immediately above. The updated Financial Model is attached as [Exhibit 35](#).

Exhibit 11.8 - pages 10 and 13	<p>The amounts reflected for Payments on LTD and liabilities (net of interest) on the "Baseline" and "Preliminary Efficiencies" Model Statement of Cash Flows</p>
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<p>(Adobe pgs. 2508 and 2511/2578)</p>	<p>were not consistent with amounts disclosed in the debt service schedules presented in the most recent financial statements included in the application. The financial model notes referenced a "Debt Schedule" (page 6) which may provide explanation; however, this schedule was not included with the model. It was expected that the LTD and liabilities payments would agree with debt service amounts presented in the notes to the financial statements (Exhibits 11.4, Attachment F and 11.5, Attachment B) (Adobe pgs. 1559 and 2421/2578).</p>
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RESPONSE: The original financial model did not include an assumption that the New Health System would pay down particular tranches of debt. The assumption was that the New Health System would refinance each tranche as it became due. Additionally, one of the goals of this exercise was not to disclose any of the specific detail of information that each individual health system would be able to use to gain a greater insight into the other health system's financial performance. If FTI used specific debt schedules from each health system then the health systems would have been able to extrapolate competitively sensitive information.

INDEX OF DOCUMENTS

- Exhibit 1 Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area
- Exhibit 2 Revised Classification of Facilities to Reflect Substitutable Services or Products
- Exhibit 3 Information on the Structure of Physician Practices
To be provided in a subsequent response.
- Exhibit 4 Physicians Under an Exclusive Contract
To be provided pursuant to CID.
- Exhibit 5 Recalculation of Market Shares
- Exhibit 6 Copy of the Nonbinding April 2, 2015 Term Sheet
- Exhibit 7 Interim Parent Company Articles
- Exhibit 8 Interim Parent Company Bylaws
- Exhibit 9 Amended Parent Company Bylaws
- Exhibit 10 Benefits and Potential Disadvantages that may Result from the Cooperative Agreement
- Exhibit 11 List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue
To be submitted pursuant to CID.
- Exhibit 12 List of MSHA's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue
- Exhibit 13 Mountain States' Currently Planned Fixed Rate Increases
To be submitted pursuant to CID.
- Exhibit 14 Wellmont's Currently Planned Fixed Rate Increases
To be submitted pursuant to CID.
- Exhibit 15 Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services
To be submitted pursuant to CID.

- Exhibit 16 Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services
To be submitted pursuant to CID.
- Exhibit 17 Anticipated 10-Year Timeline
- Exhibit 18 Estimates for How and When the \$150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated
- Exhibit 19 Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner
- Exhibit 20 Additional Detail on the Proposed Community Reinvestment
- Exhibit 21 Template Community Health Improvement Plan
- Exhibit 22 Year-by-Year Summary
- Exhibit 23 Audited Financial Statement on MSHA as of June 30, 2015
- Exhibit 24 Mountain State's current Fitch Ratings Watch
- Exhibit 25 FTI Consulting Report
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- Exhibit 27 Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio
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To be submitted pursuant to CID.
- Exhibit 32 Physician needs Assessment from Niswonger Children's Hospital
To be submitted pursuant to CID.
- Exhibit 33 Audited Results for FY2011 to FY2015

Exhibit 34 Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

Exhibit 35 Updated Financial Model

Exhibit 1

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Services Provided by Other Providers Limited to Services and Products Provided by Facilities Physically Located in the Geographic Service Area to Those within the Geographic Service Area

Hospital Name	Hospital Affiliation	Total Discharges
Total		119,282
Total 21-County Hospitals		108,392
Total Non 21-County Hospitals		10,890
Share Outside 21 County-Area		9.1%
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773
DICKENSON COMMUNITY HOSPITAL	MSHA	5
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32
QUILLEN REHABILITATION HOSPITAL	MSHA	491
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753
NORTON COMMUNITY HOSPITAL	MSHA	3,120
SYCAMORE SHOALS HOSPITAL	MSHA	3,167
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138
INDIAN PATH MEDICAL CENTER	MSHA	5,939
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123
JOHNSON CITY MEDICAL CENTER	MSHA	22,983
CARILION TAZEVELL COMMUNITY HOSPITAL	Other	543
BUCHANAN GENERAL HOSPITAL	Other	1,041
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011
TAKOMA REGIONAL HOSPITAL	Other	2,270
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225
CLINCH VALLEY MEDICAL CENTER	Other	4,102
MORRISTOWN-HAMBLÉN HEALTHCARE SYSTEM	Other	4,916

Exhibit 2

Revised Classification of Facilities to Reflect Substitutable Services or Products

Revised Classification of Outpatient Facilities to Reflect Substitutable Services or Products

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.7%	5	0	0	0	297	302
Fitness Center	0.0%	0	0	0	0	82	82
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	9.1%	3	0	2	0	50	55
Physical Therapy	7.8%	1	0	3	0	47	51
Home Health	19.6%	8	0	2	0	41	51
Rehabilitation	39.5%	9	0	8	0	26	43
CT	59.5%	12	0	10	0	15	37
MRI	52.9%	11	0	7	0	16	34
Surgery - Endoscopy	58.3%	9	0	5	0	10	24
Urgent Care	57.1%	8	0	8	0	12	28
Surgery - Hospital-based	58.3%	9	0	5	0	10	24
Dialysis Services	0.0%	0	0	0	0	20	20
Wellness Center	18.8%	2	0	1	0	13	16
Surgery - ASC	66.7%	2	0	3	3	4	12
Chemotherapy	62.5%	4	1	5	0	6	16
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	60.0%	3	0	3	0	4	10
Cancer Center	60.0%	3	0	3	0	4	10
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	3	3
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

*Excluded 3 facilities under ASC and 2 under Urgent Care

ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

Exhibit 3

Information on the Structure of Physician Practices

This Exhibit will be provided in a subsequent response.

Exhibit 4

Physicians Under an Exclusive Contract

To be submitted pursuant to CID.

Exhibit 5

Recalculation of Market Shares

Recalculation of Shares in NEWCO Geographic Service Area for Hospitals Located in Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of WHS and MSHA Discharges	Shares of Hospitals in 21-County Area
Total		119,282	100.0%		
Total 21-County Hospitals		108,392	90.9%		
Total Non 21-County Hospitals		10,890	9.1%		
Share Outside 21 County-Area		9.1%			
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	179	0.2%	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012	0.8%	1.2%	0.9%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160	1.0%	1.3%	1.1%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704	1.4%	2.0%	1.6%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000	10.9%	15.0%	12.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773	14.1%	19.4%	15.5%
DICKENSON COMMUNITY HOSPITAL	MSHA	5	0.0%	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14	0.0%	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32	0.0%	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	491	0.4%	0.6%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757	0.6%	0.9%	0.7%
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313	1.1%	1.5%	1.2%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753	1.5%	2.0%	1.6%
NORTON COMMUNITY HOSPITAL	MSHA	3,120	2.6%	3.6%	2.9%
SYCAMORE SHOALS HOSPITAL	MSHA	3,167	2.7%	3.7%	2.9%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138	4.3%	5.9%	4.7%
INDIAN PATH MEDICAL CENTER	MSHA	5,939	5.0%	6.9%	5.5%
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123	6.8%	9.4%	7.5%
JOHNSON CITY MEDICAL CENTER	MSHA	22,983	19.3%	26.5%	21.2%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%		0.5%
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%		1.0%
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%		1.7%
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%		1.7%
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%		1.9%
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%		2.1%
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%		3.0%
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%		3.8%
MORRISTOWN-HAMBLÉN HEALTHCARE SYSTEM	Other	4,916	4.1%		4.5%
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	1,764	1.5%		
CARILION MEDICAL CENTER	Other	1,159	1.0%		
TENNOVA HEALTHCARE-PHYSICIANS REGIONAL MEDICAL CEN	Other	1,045	0.9%		
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	862	0.7%		
VANDERBILT UNIVERSITY HOSPITALS	Other	856	0.7%		
All Other		5,204	4.4%		

Exhibit 6

Copy of the Nonbinding April 2, 2015 Term Sheet



This term sheet is intended for discussion purposes only and does not constitute and will not give rise to any legally binding obligation on the part of any party to these discussions or any affiliates of any party to these discussions. None of the parties to these discussions or any of their respective affiliates shall be legally bound with respect to the transactions contemplated by this term sheet unless and until such parties have executed and delivered to each other definitive, binding written agreements in respect of such transactions.

NON-BINDING PROVISIONS	
<u>I. Transaction Structure</u>	<p>A. Wellmont and Mountain States shall adopt a statement of Shared Vision and Guiding Principles consistent with the statements attached as Exhibit A to this term sheet.</p> <p>B. The form of transaction will be the formation of a new entity which will serve as the parent of Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (the "Transaction").</p> <p>C. Wellmont and Mountain States will cause a new, not for profit, tax exempt corporation to be incorporated in Tennessee ("Newco"). Newco shall be established as an independent not for profit, Tennessee corporation which shall be governed by a Board of Directors composed of residents from the Tri-Cities area of Tennessee and Virginia as set forth below.</p> <p>D. Wellmont and Mountain States collectively (the "Parties") will amend, modify or revise their respective articles and bylaws to designate Newco as the sole corporate member of each of the Parties.</p>
<u>II. Timing and Due Diligence</u>	<p>A. The Parties will mutually agree on a time schedule for conducting and completing due diligence and negotiating the Definitive Agreement, it being contemplated that such actions will be completed within one hundred fifty (150) days following signing of this term sheet.</p> <p>B. Subject to the "Protocols on Information Sharing" section below, each of Mountain States and Wellmont shall use reasonable efforts to provide access to the information, employees or contractors requested by the other Party on a timely basis and shall provide to the other Party reasonable access to its facilities upon prior notice.</p> <p>C. Neither Party (nor such Party's representatives) will contact the employees or other personnel of the other Party (including without limitation members of the medical staffs of such Party's hospitals, and no inspection will be conducted, without such Party first coordinating such inspection or contact with, in the case of Wellmont, <u>Gary Miller, Esq.</u> or his designees and in the case of Mountain States, <u>Tim Belisle, Esq.</u> or his designees.</p>
<u>III. Governance - Board of Directors</u>	<p>A. After execution of this term sheet or similar legal document, Wellmont and Mountain States will, at the appropriate and mutually agreed upon time, jointly engage third party consultants to assist with the selection, development, education and various other tasks related to establishing and integrating the Newco Board, as well as a third party consultant to conduct a culture audit of the two organizations in order to better inform</p>



the Newco Board on how best to integrate the two organizations from a human relations and cultural standpoint.

- B. Upon execution of this term sheet or similar legal document, Wellmont and Mountain States will each nominate an equal number of their existing board members to become members of the pre-closing Joint Board Task Force. Further, the CEOs of Wellmont and Mountain States will each serve on the Joint Board Task Force. The total number of members of the Joint Board Task Force will not exceed 14. This Joint Board Task Force will oversee the pre-closing activities of the Integration Council. Given the significance of issues to be managed pre-closing, it is highly desirable the individuals who are selected to serve on the Joint Board Task Force also be those who will ultimately serve on the Newco Board.
- C. The initial Newco governing board will be comprised of 14 voting members, as well as two ex-officio voting members and one (1) ex-officio non-voting member. The two ex-officio voting members shall be the Newco Executive Chairman/President and the Newco Chief Executive Officer.
 - 1. The Newco Chief Executive Officer will serve as a voting member of the Newco Board for not longer than two (2) years. At the conclusion of the Chief Executive Officer's two (2) year term, the Chief Executive Officer will rotate off the Newco Board. Upon rotation of the Chief Executive Officer off of the Newco Board, the initial Wellmont designees to the Newco Board (as described in Section D. below) shall appoint a new member to the Newco Board to replace the Chief Executive Officer. The initial term of this new Board member shall be three (3) years, with the opportunity to serve on additional three (3) year term.
 - 2. The one ex-officio non-voting member shall be the then current President of East Tennessee State University.
 - 3. The Board shall include not less than 4 licensed physicians who are members of the medical staff of one or more Newco-affiliated hospitals, with at least two (2) physicians from each legacy system. The total Newco board shall be composed of a maximum of sixteen (16) voting members.
 - 4. Should there be a change in the Executive Chairman/President within the first twenty-four (24) months, for any reason, it is the intent of both Parties to define a process for inclusion in the Definitive Agreement that would maintain the balance of the Newco Board between the legacy systems.
- D. Wellmont and Mountain States will each designate 6 members to serve on the initial board of Newco. Wellmont and Mountain States will jointly select 2 members of the initial Newco board, who will not be incumbent members of either Party's board.
- E. The initial members of the Newco board will be selected with the goals of

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(1) obtaining a broad range of competencies, skills and experience relevant to the governance of a large healthcare system and (2) ensuring broad representation from the region, employer and patient communities served by Newco. Both organizations agree the ultimate goal is for Newco to be governed by a board that is competency-based and utilizing industry best practices.

- F. The initial Newco board appointments will be for staggered terms, with 6 members having a term of two (2) years, four (4) board members with terms of three (3) years, and four (4) board members with terms of four (4) years. The two (2) Board members jointly appointed by the initial Wellmont and Mountain States members shall be in the class with an initial four-year term. The initial board members may serve their initial terms and one additional three-year term. Thereafter, limits on the number of terms of service for board members who succeed the initial board members will be agreed upon and set forth in the Newco bylaws to be adopted at the closing. For the first four years, the staggered terms shall be constructed so that legacy Board members from Wellmont and Mountain States will roll off the Board in equal numbers. If a legacy member resigns or is removed from office during his or her initial term, the person appointed to that position shall come from the same legacy organization and shall serve the unexpired term. Any renewal terms shall be subject to customary board governance policies and procedures.
- G. As and after the initial board terms expire, the Newco board will be self-perpetuating. Newco bylaws will provide that Board members will be subject to term limits as discussed above.
- H. The Newco board will have the ultimate fiduciary duties and governing role for the key business decisions, activities and management of the new health system. The Newco Board shall adopt governance best practices, including periodic performance evaluation. The governance best practices shall be further enumerated in the Newco bylaws.
- I. The Definitive Agreement shall provide for an Executive Chairman (see Section IX *infra*) and a Vice Chairman/Lead Independent Director (to be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force and named in the Definitive Agreement) whose responsibilities will be substantially similar to the description attached as Exhibit B to this term sheet. The term of the initial Vice Chairman/Lead Independent Director will be two years after the closing.
- J. The Officer and Executive Committee positions of the Newco Board will be defined in the initial Newco Bylaws to be adopted in accordance with the Definitive Agreement. There will be 4 Board Officer positions to be filled as follows: Executive Chair, Vice Chair, Treasurer, and Secretary. Additionally, there will initially be two at-large members of the Executive Committee.
- K. Upon closing of the Transaction and the constitution of the Newco Board, the existing Wellmont and Mountain States Boards may be delegated certain responsibilities by the Newco Board, such as credentialing,



	<p>subsidiary and joint-venture oversight, and implementation of Newco Board decisions as required to transition to one governance structure. It is anticipated that the Wellmont Board and Mountain States Board will be dissolved at such time that the Newco Board makes the decision to do so, but not later than 24 months after the closing of the Transaction, with their functions, authority and responsibilities transferred to the Newco Board and its Committees. It is also anticipated that during the transition period between closing and dissolution of each board, the existing Wellmont Board and Mountain States Board will have delegated responsibility for the following:</p> <ol style="list-style-type: none">1. Medical staff credentialing and oversight as those functions currently are outlined in each organization's bylaws;2. Official business of any subsidiary corporation subject to Newco Board's final authority as sole Member over such decisions; and3. Regulatory oversight such as those requirements contained within the accreditation standards for hospitals and all other subsidiary services.
<p>IV. <u>Governance - Board Subcommittees</u></p>	<ol style="list-style-type: none">A. Board committees will also be established with initial membership of equal representation by and from the Parties.B. Likely committees will include: Executive, Audit; Finance; Legal/Regulatory/Compliance; Quality; Human Resources; Governance; Investments; and Nominating.C. The final committee structure, committee charters, initial membership, and initial chairs of each will be mutually agreed upon and defined in the Definitive Agreement.D. The Executive Chairman/President of Newco will be an ex-officio, non-voting member of the Nominating Committee. The Nominating Committee charter will establish the criteria for selecting future board and committee members.
<p>V. <u>Supermajority Items</u></p>	<ol style="list-style-type: none">A. For a period of time post-Transaction, not to exceed two (2) years, certain board actions will require approval by a supermajority (defined as two-thirds) vote.B. The specific list of actions requiring supermajority approval will be identified in the Definitive Agreement, but will include the following:<ol style="list-style-type: none">1. Amendments to Newco charter and bylaws;2. Sale of substantially all of the assets of Newco, or merger of Newco with or into another entity;3. Sale or closure of any hospital;4. Debt incurrence above an amount to be set forth in the Newco bylaws;5. Decision to file bankruptcy or insolvency proceedings or to seek

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	<p>appointment of a receiver for Newco or key members of its group(s) obligated to repay long-term debt; and</p> <p>6. Discontinuing major clinical services, to be defined in the Definitive Agreement, at a Newco affiliated hospital.</p>
<p>VI. <u>Hospital and Affiliate Governance</u></p>	<p>A. Subject to the provisions of any existing joint-venture and other contractual agreements, the governing boards of all hospitals and other affiliates will be appointed by, and serve at the pleasure of, the Newco board. The Newco Board shall have final authority as sole Member of Newco's ownership interest in any hospital, joint-venture or partnership.</p> <p>B. Except as provided below, the existing governing boards of hospitals and affiliates as of the Transaction closing will continue to serve unless replaced by the Newco board.</p> <p>C. To the degree any of the Boards of any subsidiary or wholly owned corporations of Wellmont and Mountain States have membership constituted to include Board members of Wellmont or Mountain States, such board composition shall be amended such that there is equal representation from Wellmont and Mountain States Board members.</p> <p>D. The composition of the boards of the respective physician organizations of Wellmont and Mountain States will be approved by the Newco Board.</p> <p>E. The charters of the Wellmont and Mountain States foundations will require that their respective funds as of the Transaction closing must be used consistent with the intent of the original donors thereof.</p>
<p>VII. <u>Integration Council</u></p>	<p>A. As legally appropriate after the execution of this term sheet or similar legal document, the Parties will establish an Integration Council comprised of ten to twelve (10-12) members. The Integration Council will have responsibility for retaining an independent consultant to undertake a comprehensive analysis of the clinical, operational and financial functions of Wellmont and Mountain States to (1) identify, substantiate and quantify the cost-savings and quality-enhancement opportunities achievable specifically from the Transaction and (2) describe the timeline and integration plan for achieving these opportunities. The Integration Council will engage, on a regular basis, with this consultant for periodic reports on his/her analysis and supply information as needed to further the analysis, and prepare the Parties for integration to ensure the realization of Newco's clinical, operational and financial potential post-Transaction. The objective of the Integration Council is to ensure a system approach that best serves the needs of the community and region based on objective information.</p> <p>B. Integration Council members may include operating executives, finance executives, legal executives and physician executives. Physician, nurse and other clinical and administrative leaders, shall be called upon to provide input and support to the Integration Council. The Integration Council will be composed of an equal number of representatives from Wellmont and Mountain States. There shall be at least four (4) members of the</p>

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	<p>Integration Council who shall be physicians, with two (2) representatives from each of Wellmont and Mountain States. At least one (1) of each health system's physician representatives on the Integration Council shall be a physician in independent practice from each system.</p> <p>C. Wellmont and Mountain States may jointly engage additional third party consultants to advise the Integration Council, as needed.</p> <p>D. After the execution of this term sheet or similar legal document and until the Transaction closing date, the Integration Council will report to the Joint Board Task Force, to be comprised of existing Wellmont and Mountain States Board members, and the CEOs of Wellmont and Mountain States, acting in a transaction committee role.</p> <p>E. All of the activities of the Integration Council prior to Transaction close shall be reviewed and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions.</p> <p>F. The Integration Council shall develop a draft Newco policy outlining the process for consolidating services and facilities, which policy shall include but not be limited to cultural integration, timetables for actions, input from physicians impacted, and notices to staff and community. The draft policy shall be submitted to the Newco board for approval. Post-Transaction, the Integration Council will cease operations and its functions shall be assumed by the Newco management team.</p> <p>G. The Parties will mutually agree and define in the Definitive Agreement the ongoing activities, terms of service and scope of the Integration Council within Newco post-Transaction.</p>
<p>VIII. <u>Clinical Council</u></p>	<p>A. Promptly after the Transaction closing, Newco commits to the development of a physician-led Clinical Council (composed of appropriate balances of private physicians, group practice physicians and employed physicians) to guide, oversee and assist in implementation of the plan to integrate clinical activities, service lines and business units, and to advise on any appropriate further clinical integrative actions post-implementation that would result in added growth, operational efficiencies and advancements in patient care. Post-closing, the initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or Mountain States.</p> <p>B. The Clinical Council will include Newco management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Newco. The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Newco-affiliated hospitals, will serve on the Quality Committee of the Newco Board, and will provide ongoing reports on the activities of the Clinical Council to the Newco Board through the Quality Committee function of the Board.</p> <p>C. Among other duties, it is anticipated the Clinical Council will work on areas, among others, such as establishing a common standard of care,</p>



	common credentialing, consistent multidisciplinary peer review, where appropriate, and quality performance standards
IX. <u>Newco Management</u>	<p>A. The initial management team (“Initial Management Team”) of Newco shall be as follows:</p> <ul style="list-style-type: none">• Executive Chairman/President: Alan Levine<ul style="list-style-type: none">○ The Executive Chairman/President will be the senior officer of the organization. The evaluation of the Executive Chairman/President’s performance will reside with the Newco Board.• Chief Executive Officer: Bart Hove<ul style="list-style-type: none">○ The Chief Executive officer will report to the Executive Chairman/President.• Chief Operating Officer: Marvin Eichorn<ul style="list-style-type: none">○ The Chief Operating Officer will report to the Chief Executive Officer.• Chief Financial Officer: Alice Pope<ul style="list-style-type: none">○ The Chief Financial Officer will report to the Chief Executive Officer. <p>The position description for the Executive Chairman/President shall be substantially similar to the position description attached as Exhibit C to this Term Sheet and ensure the position is the most senior officer of Newco. The Joint Board Task Force will develop and approve the Executive Chairman/President’s contract for inclusion as an exhibit to the Definitive Agreement, and to be executed by the Newco Board upon the closing of the Transaction</p> <ul style="list-style-type: none">• Concurrently with the process for development of the Contract with the Executive Chairman/President, the Executive Chairman/President shall, on behalf of the Joint Board Task Force, negotiate an employment agreement with the Chief Executive Officer for ratification by the Joint Board Task Force. This contract will be included as an exhibit to the Definitive Agreement, and will be executed by the Executive Chairman/President and Chief Executive Officer upon the closing of the Transaction. The position description for the Chief Executive Officer shall be substantially similar to the position description attached as Exhibit D to this Term Sheet.• The Chief Executive Officer, in consultation with the Executive Chairman/President, will then develop job descriptions for the remaining Initial Management Team members for inclusion as an exhibit to the Definitive Agreement. <p>B. The Executive Chairman/President and the Chief Executive Officer of</p>

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	<p>Newco will begin the process of assembling the Newco management team (comprised of the direct reports to the Executive Chairman/President and the Chief Executive Officer other than the Initial Management Team), which shall be presented to the Newco Board for approval after the closing. It is anticipated that the Newco management team will be composed of representatives from each Party and will not be composed of the management team from a single Party.</p> <p>C. Upon signing of this term sheet or similar legal document, Wellmont and Mountain States will identify to each other those senior executives with whom each has executed, or will execute, retention and severance agreements.</p> <p>D. It is in the best interest of Newco that the corporate headquarters are easily accessible and conveniently located. Within 2 years of closing, the Newco Board will direct that the Newco Senior Management Team evaluate the most suitable, cost-effective and appropriate location of the corporate headquarters and to make a recommendation to the Board for consideration and approval. The Newco corporate headquarters shall not be located on the campus of any Newco affiliated hospital.</p>
<p>X. Employees</p>	<p>A. Newco and affiliates will continue employment of (or, as appropriate, extend offers of employment to) all active employees of the Parties upon substantially similar terms and conditions with respect to base salaries and wages, job duties, titles and responsibilities that are currently provided to such employees immediately prior to close, except that certain positions which are identified as synergies may be eliminated. Normal employment practices, including terminations and reductions in force, will be unaffected.</p> <p>B. Newco will honor prior service credit under each Parties' employee plans for purposes of eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties' employee benefit plans. Newco will provide all employees credit for accrued vacation.</p> <p>C. Newco will work as quickly as practicable after closing to address any required actions with respect to differences in salary/ pay rates and employee benefit structures with a goal of creating consistency throughout the merged health system wherever feasible.</p>
<p>XI. <u>Medical Staff</u></p>	<p>A. Newco is committed to a pluralistic, physician-led medical staff model that embraces the strengths of private practice, group practice and employed physicians.</p> <p>B. The medical staff members in good standing immediately prior to Transaction closing will maintain their medical staff privileges at the Parties' facilities where such privileges are maintained, subject to the medical staff</p>

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	<p>bylaws then in effect.</p> <p>C. Subject to completion of due diligence, Newco will continue all existing contracts with physicians, including employment agreements, at least until the initial expiration of such contracts.</p> <p>D. All medical staff bylaws of each legacy system will remain in effect until such time as Newco and each respective medical staff develop and approve a new or modified set of medical staff bylaws, should new or modified medical staff bylaws be deemed necessary.</p>
<p>XII. <u>Existing Affiliations</u></p>	<p>A. Newco will initially maintain the Wellmont and Mountain States joint ventures, affiliations and other outsourced contracts/relationships existing at close.</p> <p>B. Opportunities to optimize such structures will continue to be evaluated by the Newco board and the Integration Council post-Transaction.</p> <p>C. Prior to closing the Transaction any potential conflicts arising under such arrangements that are caused by the Transaction shall, subject to prior advice of counsel, be identified and reviewed by the Integration Council and the Joint Board Task Force. Recommendations by the Integration Council for post-closing actions by Management or Newco Board will be reported to the Board and Counsel.</p>
<p>XIII. <u>Information Technology</u></p>	<p>A. The Definitive Agreement will provide that all Newco hospitals will fully integrate into the EPIC information system currently used by Wellmont.</p>
<p>XIV. <u>Insurance Platforms</u></p>	<p>A. As soon as practicable after closing, Newco will review the structure of the existing insurance platforms of Wellmont and Mountain States and work to spread risk, reduce costs and realize efficiencies that result from the Transaction</p>
<p>XV. <u>Philanthropic Gifts</u></p>	<p>A. Newco will honor the intent of all gifts, bequests, grants and donations provided to either Mountain States or Wellmont by a donor to be used for charitable purposes by a tax-exempt organization.</p>
<p>XVI. <u>Community Benefit</u></p>	<p>A. Newco commits to operate in accordance with the "community benefit standards" as they apply to 501c(3) hospital non-profit corporations, including, without limitation, the (i) acceptance of all Medicare and Medicaid patients, (ii) acceptance of all emergency patients without regard to ability to pay, (iii) maintenance of an open medical staff, (iv) provision of public health programs of educational benefit to the community, and (v) general promotion of public health, wellness, and welfare to the community through the provision of health care at a reasonable cost.</p> <p>B. The Definitive Agreement will commit Newco to maintaining the Parties' existing or equivalent community benefit and education programs and services at close.</p> <p>C. In the context of supporting the Certificate of Public Advantage, Newco will conduct, in partnership with East Tennessee State University and other Academic partners, as appropriate, a detailed public health needs</p>



	<p>assessment in order to identify and prioritize measurable health needs and initiatives. Such initiatives may include, but not be limited to:</p> <ul style="list-style-type: none">• The establishment of a long-term strategy for improving the health status of the region served by the merged system that supports both the Tennessee and Virginia state health plans;• Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities;• Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years;• Establishment of programs to improve health literacy;• Development of programs to improve child wellness – physical and emotional;• Growth of medical research programs; and• Expansion of academic opportunities, to include, but not be limited to, expansion of new fellowships and other opportunities to allow physicians and allied health professionals to train and serve in health professional shortage areas within the region. <p>D. Newco will abide by policies and provisions of charity care that are no less generous than the policies of the Parties at the time of the Transaction closing, subject to changes in law, policy or regulation as applicable.</p>
<p>XVII. <u>Naming/ Branding</u></p>	<p>A. The Parties will work to mutually agree to the renaming and rebranding of Newco. Upon signing of this term sheet, Wellmont and Mountain States will mutually agree upon and jointly retain a firm to advise and assist them with the rebranding strategy. The rebranding strategy will have goals of establishing a single identity for the merged system that communicates its mission and clearly informs all members of the regional community of the new name, logo(s), and the mission of the merged system.</p>
<p>XVIII. <u>Approvals; Termination</u></p>	<p>A. The execution and delivery of the Definitive Agreement are conditioned on the receipt of all necessary consents and approvals of the appropriate governing boards of Mountain States and Wellmont. Furthermore, it is anticipated that the Definitive Agreement will provide that the consummation of the Transaction will be conditioned upon:</p> <ol style="list-style-type: none">1. The receipt of all material consents of third parties, if any, necessary under material agreements of the Parties for consummation of the Transaction contemplated under the Definitive Agreement;2. The filing of all notices and the receipt of all approvals and consents, as required from governmental authorities (including, if applicable, the Attorneys General of the States of Tennessee and Virginia);3. The termination of any waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; and

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	<p>4. The satisfaction of such other conditions as are mutually acceptable to the Parties or are legally required.</p> <p>B. It is the intent of both Parties, upon execution of the Definitive Agreement, that both Parties will take all reasonable steps necessary to close the Transaction. Notwithstanding the foregoing, both Parties recognize there may be circumstances of federal and/or state government action or inaction, or extraordinary external factors, that may give rise to the conclusion that the Transaction may be imperiled or it is no longer reasonable to pursue closing of the Transaction. Consequently, the Definitive Agreement shall articulate circumstances upon which either Party may unilaterally terminate the Transaction.</p>
<p>XIX. <u>COPA</u></p>	<p>A. Without limiting the approvals described above, simultaneously with the negotiation of the Definitive Agreement, the Parties will negotiate a "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993 (the "Act").</p> <p>B. Following execution of the Definitive Agreement, the Parties will apply to the Tennessee Department of Health to obtain, and follow the procedures under the Act for obtaining, a certificate of public advantage (the "Tennessee COPA") to govern the cooperative agreement as provided in the Act.</p> <p>C. At the appropriate time, the Parties shall apply to the Virginia Attorney General, or other appropriate state agency or entity, for a consent order or other appropriate state approvals regarding Newco Virginia operations on substantially the same terms as the Tennessee COPA (the "Virginia Consent Order").</p> <p>D. Subject to the provisions articulated in Section XVIII, Paragraph B above, each Party shall use good faith efforts to obtain the Tennessee COPA and other regulatory approvals necessary to closing of the Transaction. The Definitive Agreement will provide that receipt of the Tennessee COPA and the Virginia Consent Order, or comparable approval, on terms satisfactory to the respective Wellmont and Mountain States Boards, in their reasonable discretion, is a condition to the Parties' respective obligations to complete the Transaction.</p>
<p>BINDING PROVISIONS</p>	
<p>XX. <u>Confidentiality and Disclosure</u></p>	<p>A. The Parties have previously entered into a confidentiality agreement dated April 2, 2014 (the "Confidentiality Agreement"). In addition to the provisions contained in that agreement, except as and to the extent required by law, without the prior written consent of the other Party, neither Mountain States nor Wellmont shall, and each shall direct its representatives not to, directly or indirectly, make any public comments, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of discussions regarding a possible Transaction or any of the terms, conditions or aspects of the Transaction proposed in this term sheet except in the manner provided by the</p>

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	<p>Confidentiality Agreement. The timing, content and context of any announcements, press releases, public statements, or reports and related matters incident to the matters referenced in this term sheet, or its existence, will be determined in advance by the mutual written consent of the Parties. Further, the Parties will advise each other of communications to their employees and medical staff relating to the Transaction prior to the communication of the same.</p>
<p>XXI. <u>Protocols on Information Sharing</u></p>	<p>A. The Parties recognize that disclosure of certain information may raise unique legal concerns due to the proximity of the Parties' operations and facilities ("Competitive Sensitive Information"). Such Competitive Sensitive Information may include, but is not limited to, information about prices, pricing formulas, costs, rates of provider compensation, strategy or intentions regarding contracting with any provider or purchaser, fee schedules, managed care contracts, premium rates, compensation or benefits information relating to employees, recruitment of medical professionals or others, future expansion plans involving clinical services or pertaining to physicians, and any non-public marketing or strategic planning documents or other competitively sensitive documents relating to a party's future plans. The Parties will only disclose Competitive Sensitive Information in accordance with law as agreed to in advance by the Parties' and their respective legal counsel and to that end, the Parties may enter into one or more protective agreements or develop other arrangements to address the review of such Competitive Sensitive Information to ensure compliance with applicable law.</p>
<p>XXII. <u>Transaction Expenses; Exclusive Negotiations</u></p>	<p>In view of the substantial time and expense involved in obtaining required regulatory approvals, due to the innovative nature of the Transaction:</p> <p>A. With respect to the expenses of the Tennessee COPA (including experts and the Wellmont counsel fees), the Virginia Consent Order and other expenses arising out of this term sheet and the Transaction (collectively referred to as "Expenses"), whether or not the Transaction or any part thereof shall close, Mountain States shall bear 70% of the Expenses, while Wellmont shall bear 30% of the Expenses.</p> <p>B. In consideration of the Parties' significant investment of time and expense in connection with the transactions contemplated by this term sheet, from the date of execution of this term sheet or similar legal document until written termination of negotiations are received by the other Party, neither Party may, without the written approval of the other Party, make or solicit offers for, or hold discussions or negotiations or enter into any agreement with respect to, (a) the sale, lease or management of any of its hospitals or any material portion of its assets or any ownership interest in any entity owning any of its hospitals or any material portion of its assets, (b) any reorganization, merger, consolidation, management agreement, member substitution or joint venture involving any of its hospitals or any material portion of its assets, or (c) any other transaction in which a person or group other than the other Party would acquire the right, directly or indirectly, to</p>

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	control the governing board of, direct the operations of, establish governing or operating policies for, and/or own, lease or otherwise acquire the right to use or control, any of such Party's hospitals or any material portion of its assets (the "Exclusive Negotiations Covenant").
XXIII. <u>Nature of Term Sheet</u>	<p>A. The Parties agree that, except for Sections XX-XXIV hereof, this Term Sheet is not intended to be a binding agreement and shall not give rise to any obligations between the Parties.</p> <p>B. Further, due to the complexity of the proposed transaction, it is the expressed intention of the parties that, except for the provisions of Sections XX-XXIV, no binding contractual agreement shall exist between them unless and until Mountain States and Wellmont (and any other necessary parties) shall have executed and delivered a Definitive Agreement, which shall contain the provisions outlined above and the representations, warranties, and other terms and conditions customary in this type of transaction, all of which must be acceptable to all parties in their sole discretion (including, without limitation, contingencies for all necessary regulatory approvals). Any Party may for whatever reason terminate this term sheet and further negotiations by written notice to the other Party. In such event, there shall be no liability between any of the Parties as a result of the execution of this term sheet, any acts or omissions of the parties or their representatives in connection with the proposed transaction, any action taken in reliance on this term sheet, or such termination, except as set forth in Sections XX-XXIV hereof. Notwithstanding the foregoing, termination by either party of this term sheet shall not terminate or otherwise affect the obligations the parties may have to each other pursuant to the Confidentiality Agreement, and pursuant to any separate agreement entered into with respect to Competitive Sensitive Information.</p> <p>C. Prior to execution, this term sheet shall be approved by the Board of Directors of both Wellmont and Mountain States.</p>
XXIV. <u>Governing Law</u>	<p>A. The Transaction definitive documents shall be governed by and construed in accordance with the laws of the State of Tennessee without reference to principles of conflicts of law. Wellmont counsel shall prepare the initial drafts of definitive documents.</p>

(signatures on the following page)

IN WITNESS WHEREOF, the parties hereto have caused this term sheet to be executed in multiple originals by their duly authorized officers, all as of the date first above written.

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MOUNTAIN STATES HEALTH ALLIANCE

By: Barbara Allen
Barbara Allen
Chair

By: Alan Levine
Alan Levine
President and CEO

WELLMONT HEALTH SYSTEM

By: Roger Leonard
Roger Leonard
Chairman

By: Bart Hove
Bart Hove
President and CEO

Exhibit A

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Shared Vision and Guiding Principles

A Shared Vision for Regional Healthcare

It is the shared vision of our boards that Wellmont Health System and Mountain States Health Alliance come together as equal partners to develop a brand new health system for our region with a new leadership structure, a new board, a new name, and a new kind of vision. This new leadership structure and board will work to unite the resources of both systems with one common purpose—to become one of the best regional health systems in the nation..

As one of the largest health systems and employers in the state of Tennessee, this new system will—

- Establish new unifying mission, vision, and values statements that honor our heritage and charter our future
- Be one of the strongest health systems in the country, known for outstanding clinical outcomes and superior patient experiences
- Be one of the best health system employers in the country and one of the most attractive health systems for physicians and employee team members
- Create new models of joint physician and administrative leadership to shape the future of healthcare in our region through substantial physician influence and direction
- Partner with physicians to achieve better quality at lower cost for patients, businesses, and payers
- Achieve long-term financial stability and sustainability through wise stewardship of resources, avoidance of waste, and sound fiscal management
- Advance high-level services so that more people can receive the care they need close to home
- Be a national model for rural healthcare delivery and rural access to care
- Work with regional educational and allied health partners to identify health gaps and disparities and effectively meet community health needs
- Create an efficient, high quality healthcare system that attracts employers to our region and creates long-term economic opportunity
- Build new population health models and leverage electronic health records and community engagement programs to reduce unhealthy behaviors and improve the overall health status of our region
- Work with academic partners, in particular East Tennessee State University, in new ways to bolster medical school and allied health programs and attract research investments
- Establish innovative philanthropic partnerships for healthcare advancement

To accomplish these objectives, we will seek to build shared vision with our team members and physicians and invest in their success. As a health system of choice, the new system will benchmark

against the best health systems in the nation to create an environment that advances our team members and physicians.



Our integration should be methodical and intentional, guided by achieving clear value for the community, our team members, and our physicians. A substantial period of initial assessment will be needed and will result in a long-term strategic vision for the new system. During the assessment and planning period, it will be important to maintain clinical services in our current communities and move forward to address any access gaps across the region. We commit to open communication through rotating quarterly town hall meetings and other methods to keep our communities and physicians informed about our plans and our progress.

Working together, focused solely on what is in the best interests of our physicians, team members, patients, and communities we will set a new standard for healthcare excellence and bring unprecedented value to our region guided by the principles that follow.

Guiding Principles for a New Regional Health System

Beyond a shared vision to develop one of the best health systems in the nation, the new not for profit health system created by the merger of Wellmont Health System and Mountain States Health Alliance will be guided by the following principles and will develop strategic plans to deliver on them.

Mission, Vision, and Strategy

- Exhibit common values and a compelling vision for healthcare delivery in the region
- Achieve cultural integration across key stakeholder groups and embody a culture of collaboration
- Demonstrate commitment to the Triple Aim of improving the patient experience through enhanced quality and satisfaction, improving the health of populations and reducing the per capita cost of healthcare

Patients

- Demonstrate a commitment to first class patient experiences and broad community support for programs and services
- Improve and advance the overall health status of patients and communities served, including both healthcare and wellness services, to improve their ability to stay well
- Commit to serving all people in each community—including those with and without the ability to pay
- Develop regional community health needs assessments and implementation plans and update these annually to ensure healthcare gaps and disparities are addressed
- Keep the best interest of patients at the center of everything we do, delivering exceptional value and high quality outcomes

- Facilitate patient access to their preferred physicians
- Create the best practice environment for the physicians who care for our patients
- Maintain and further develop highly specialized medical services



Physicians

- Support and strengthen our valued community of independent physicians as well as currently employed physicians for the benefit of high-quality patient outcomes
- Create an environment and culture that is attractive to highly qualified physicians and that places equal value on the roles of both independent and employed physicians
- Ensure all physicians have the resources needed to access clinical information and collaborate in the best interest of patients
- Broaden expertise and resources to enhance local medical staff leadership and professional development
- Commit to physician leadership at all levels of system and local administration

Employees

- Maintain or improve compensation and benefits for employees to levels that are competitive in comparable markets throughout the Southeastern United States and maintain the tenure of employees for eligibility and other purposes
- Create industry leading educational and professional development programs, including continuing education and clinical education
- Create an employment environment that will attract and retain highly qualified clinical and administrative talent in service to our communities

Clinical Programs, Service, and Quality

- Develop cohesive resources to effectively coordinate the provision of services across the system and ensure seamless access to high quality, cost-effective healthcare services
- Seek to improve primary care access and develop NCQA, level 3 patient-centered medical homes
- Effectively manage rural facilities and align tertiary resources to ensure timely access to appropriate care
- Expand clinical trial programs in heart, cancer, and other areas
- Design a seamless regional care continuum across a full spectrum, including pre and post acute care

Management & Operations

- Seek opportunities to leverage economies of scale for operational efficiency in corporate management and back office functions
- Enhance clinical support functions that will advance service excellence and quality outcomes
- Leverage any unique capabilities, assets, and programs to maximize effectiveness and efficiency
- Develop proficiency in implementation and management processes and protocols to redesign care, reduce variation, and systematically improve outcomes while lowering cost

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Investment and Innovation

- Endeavor to remain on the forefront of future developments in healthcare technology
- Develop effective purchasing and financing systems to improve overall cost of capital
- Achieve and maintain an improved approach to overall financial management, resulting in improved finances and bond ratings
- Build a comprehensive Epic platform to support clinical integration, population health management, and connectivity
- Achieve sufficient financial security to ensure commitment of capital and investment in new services, technology, and facilities.

Population Health Management

- Focus on the purposeful development of a care management/population health model
- Support advancement of population health management locally through quality incentive and risk-bearing payment arrangements, among other appropriate mechanisms
- Develop necessary informatics and analytic systems to support partnerships with payers and employers in new compensation and insurance models.

Governance

- Instill industry leading governance structures and practices that effectively represent the communities we serve and showcase physician leadership
- Ensure the system possesses the resources, talent, and technology needed to thrive both in the current and the emerging healthcare industry

Exhibit B

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Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

The Vice Chair/Lead Independent Director coordinates the activities of the other non-management Directors, and performs such other duties and responsibilities as the Board of Directors may determine.

The specific responsibilities of the Vice Chair/Lead Independent Director are as follows:

Presides at Executive Sessions

- Presides at all meetings of the Board at which the Executive Chairman/President is not present, including executive sessions of the independent Directors.

Calls Meetings of Independent Directors

- Has the authority to call meetings of the independent Directors.

Conducts Evaluation of Executive Chairman/President

- Ensures independent Director evaluation of the Executive Chairman/President by the Board, including an annual evaluation of his or her performance and compensation.

Functions as Liaison with the Executive Chairman/President

- Serves as liaison between the independent Directors and the Executive Chairman/President.

Approves appropriate provision of information to the Board such as board meeting agendas and schedules

- Approves meeting information sent to the Board relating to agendas and actions items, including the quality, quantity and timeliness of such information.
- Setting the Board's approval of the number and frequency of Board meetings, and approves meeting schedules to assure that there is sufficient time for discussion of all agenda items.

Authorizes Retention of Outside Advisors and Consultants

- Authorizes the retention of outside advisors and consultants who report directly to the Board of Directors on board-wide issues upon approval of the Governance Committee.

Constituent Communication

- If requested by constituent groups, ensures that he/she is available, when appropriate, for consultation and direct communication.

Exhibit C

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Description of the Executive Chairman/President Position

Executive Chairman/President

Leadership

- Leadership of the board; ensuring the board's effectiveness and engagement in all aspects of its role and, in conjunction with the Vice Chair, setting of its agenda.
- Directing activities which serve to promote the mission.
- Consistent with the shared vision statement, setting the direction for the organization by shaping the vision, setting the strategy, and leading critical negotiations with potential partners.
- Shaping a positive culture: setting the standards, modeling Newco's values, to include a focus on 'system-ness' and value-based performance, research and academics, and innovation.
- In conjunction with the Chief Executive Officer: building leadership capability of the management team; selecting, developing and motivating key leaders and high potential talent to ensure future leadership is capable of meeting current and future organizational needs and is held accountable for system-wide performance.
- Promoting the highest standards of corporate governance.

Meeting

- Chairing board meetings.
- In conjunction with the Vice Chair, ensuring the board's effectiveness in all aspects of its role, including regularity and frequency of meetings.
- In conjunction with the Vice Chair, setting the board agenda, taking into account the issues and concerns of all board members. The agenda should be forward looking, concentrating on strategic matters.
- Ensuring that the directors receive accurate, complete, timely and clear information, and are advised of all likely future developments and trends, to enable the board to take sound decision and promote the success of the company.

Directors

- Facilitating the effective contribution of directors and encouraging active engagement by all members of the board.
- Ensuring constructive relations among the directors and between the directors and management.
- Building and maintaining an effective competency based and complementary board, and with the Nomination Committee, initiating change and planning succession in board appointments subject to the bylaws and board approval.

Induction, Development and Performance Evaluation

- Ensuring new directors are oriented, and provided adequate opportunity to on-board.
- Ensuring that the development needs of directors are identified and met. The directors should be able to continually update their skills, knowledge, and familiarity with the company.
- In conjunction with the Vice Chair, identifying the development needs of the board as a whole to enhance its overall effectiveness as a team and to ensure it receives board education consistent with industry standards for a system of the size and scope of Newco.

- Ensuring the performance of the board, its committees and individual directors is evaluated periodically through the Board Governance Committee, and acting on the results of such evaluation.

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Relations with Stakeholders

- Ensuring effective communication with all stakeholders, financial institutions, the public and government/regulatory agencies. Serve as the Chief Spokesperson for the Organization with appropriate delegation of authority to the CEO on operational matters.
- Representing Newco to Federal, State and local governing bodies and, either in person or through a designee, serve as Chief Spokesperson and advocate for the interests of Newco and on healthcare issues in general.
- Maintaining and promoting Newco's public image and reputation.

Direct Reports

The direct reports to the Executive Chairman/President include:

- Chief Executive Officer
- Compliance and Audit (dual reporting responsibility to the Executive Chairman/President and also to Chair of Audit Committee)
- General Counsel (dual reporting to the Executive Chairman/President and to the board.)
- Corporate Communications
- System Development/Philanthropy
- Strategic Planning

Other Responsibilities

The Executive Chairman/President shall:

- Uphold the highest standards of integrity.
- Ensuring effective implementation of board decisions.
- Ensuring the long-term sustainability of the business through coordination with Newco Board and Management Team.

The Executive Chairman/President is accountable to, and reports to the Newco Board.

The Executive Chairman/President is also responsible for the following:

- Enhancement of external affiliations and relationships.
- Implementing and oversight of compliance with Certificate of Public Advantage or other regulatory agreements.
- Regular review of the operational performance of the company.
- Responsible to the Newco Board for ensuring the provision of the highest quality of patient care and customer service in all Newco facilities and business units.
- Responsible for management of the organization's debt.
- Aligning the organization: continuing to drive the integration of Newco to create a cohesive, responsive organization by eliminating redundancies, capitalizing on economies of scale, and fostering a system mentality.

Exhibit D



Description of the Chief Executive Officer Position

Chief Executive Officer

Leadership

- The Chief Executive Officer of Newco reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Newco organization. This executive position requires a combination of operational excellence and system administrative skills and must be attentive to enhanced financial performance in a physician-empowered culture. It is expected that the CEO is adroit in physician relations, physician recruitment and retention.
- This position requires visionary leadership and plays a vital role in creating, implementing and executing the strategy in conjunction with the Executive Chairman/President. Of paramount importance, this position requires the incumbent to establish credibility with employees, physicians, payors, providers and community leaders. The CEO is expected to raise the health system's visibility and reputation in the communities it serves in conjunction with the Executive Chairman/President.
- The CEO position serves as the principal operational leader for the organization and is responsible for driving forward Newco's vision to be the best healthcare delivery system in the region in conjunction with the Executive Chairman/President. This position is the champion for Newco's continued emphasis on "systemness" across the care delivery continuum, to achieve not only its quality and safety goals, but also to increase operational efficiency and provide a consistent point of service contact for its patients.

Major Responsibilities

- Possess a professional and personal adherence to the values, mission and philosophy of the Newco organization.
- Expand on the legacy of the quality and safety of patient care services across the system.
- Working closely with the Executive Chairman/President to lead the ongoing review of the current strategic plan and development of future strategic plans; ensure the plan supports the organization's goal of clinical excellence, while at the same time considers the appropriate business model for the medical staff and strategic service opportunities for growth and addresses revenue generation to sustain ongoing growth. Realize the goal of an integrated health system that leverages the advantages of a multi-state and multimarket health.

- In conjunction with the Executive Chairman/President, build a high performance culture characterized by decisiveness, accountability and compassion.



Direct Reports

- Chief Operating Officer
- Chief Financial Officer

And the following subject to development of a final organizational chart.

- Chief Medical Officer
- Vice President of Human Resources
- President of Physician Organization

Exhibit 7

Interim Parent Company Articles



BILL GARRETT, Davidson County

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Fees: 7.00 Taxes: 0.00



STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Newco, Inc.
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

September 11, 2015

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	000814276	Formation Locale:	TENNESSEE
Filing Type:	Nonprofit Corporation - Domestic	Date Formed:	09/11/2015
Filing Date:	09/11/2015 3:14 PM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2016
Duration Term:	Perpetual	Image # :	B0126-8290
Public/Mutual Benefit:	Public		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 002230945	Filing Fee:	\$100.00
Payment-Check/MO - BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, NASHVILI		\$100.00

Registered Agent Address:

CLAIRE C. HALTOM
STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Principal Address:

STE 800
211 COMMERCE ST
NASHVILLE, TN 37201-1817

Congratulations on the successful filing of your **Charter** for **Newco, Inc.** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Kelli Wiggins

ARTICLES OF INCORPORATION
OF
NEWCO, INC.

FILED

The undersigned nonprofit corporation acting pursuant to the provisions of the Tennessee Nonprofit Corporation Act, Tennessee Code Annotated, Section 48-51-101, et seq. (the "Act"), adopts the following Articles of Incorporation pursuant to Tennessee Code Annotated, Section 48-52-102:

ARTICLE I.

CORPORATE NAME

The name of the corporation is Newco, Inc. (the "Corporation").

ARTICLE II.

TYPE OF CORPORATION

The Corporation is a public benefit corporation.

ARTICLE III.

INCORPORATOR

The name, address and zip code of the incorporator is Claire C. Haltom, 211 Commerce Street, Suite 800, Nashville, TN 37201.

ARTICLE IV.

REGISTERED AGENT AND OFFICE

The registered office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201, Davidson County, and its registered agent at that address is Claire C. Haltom.

ARTICLE V.

PRINCIPAL OFFICE

The street address and zip code of the principal office of the Corporation is 211 Commerce Street, Suite 800, Nashville, Tennessee 37201.

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ARTICLE VI.

NONPROFIT STATUS

The Corporation is not for profit.

ARTICLE VII.

MEMBERS

The Corporation will not have members.

ARTICLE VIII.

PURPOSES

The purposes for which this Corporation is organized are as follows:

(a) It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the "Code"), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

(b) Notwithstanding the other provisions of these Articles of Incorporation, the Corporation shall only conduct or carry on activities permitted to be conducted or carried on by an organization exempt under Section 501(c)(3) of the Code, and by any organization contributions to which are deductible under Section 170(c)(2) of the Code.

(c) The Corporation may do any and all things hereinabove set forth, and all things usual, necessary or proper in furtherance of or incidental to the purposes of the Corporation.

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ARTICLE IX.

LIMITATIONS ON POWERS

As a means of accomplishing the purposes for which it is organized, the Corporation shall have the rights and powers now or later conferred upon corporations not for profit by the Act and the laws of the State of Tennessee, limited in certain respects as follows:

(a) The Corporation shall neither have nor exercise any power, nor shall it directly or indirectly engage in any activity, that would (1) prevent it from obtaining and maintaining exemption from federal income taxation as a corporation described in Section 501(c)(3) of the Code, (2) prevent it from obtaining and maintaining the status of a corporation contributions to which are deductible under Section 170(c)(2) of the Code, or (3) cause it to lose such exemption or status.

(b) The Corporation shall not be operated for the primary purpose of carrying on a trade or business for profit.

(c) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its directors, officers, or other private persons, except that the Corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its corporate purposes.

(d) Except as may be permitted from time to time under Section 501 of the Internal Revenue Code, no substantial part of the activities of the Corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation; nor shall it in any manner or to any extent participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office; nor shall the Corporation engage in any activities that are unlawful under applicable federal, state, or local laws.

ARTICLE X.

LIMITATION OF DIRECTOR LIABILITY

To the fullest extent that the laws of the State of Tennessee as it exists on the date hereof permits the limitation or elimination of the liability of directors, no director of the Corporation shall be personally liable to the Corporation for monetary damages for breach of fiduciary duty as a director. If the Act is amended after approval of these Articles of Incorporation to authorize corporate action further eliminating or limiting personal liability of directors, then the liability of a director of the Corporation shall be eliminated or limited to the fullest extent permitted by the Act, as amended, without the requirement for further amendment of these Articles of Incorporation.

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ARTICLE XI.

DISSOLUTION

Upon the dissolution of the Corporation, and pursuant to the laws of the State of Tennessee:

(a) All liabilities and obligations of the Corporation shall be paid and discharged, or adequate provisions shall be made therefore; and

(b) All remaining assets of the Corporation shall be distributed to one or more charitable, scientific, literary or educational organizations which are not for profit, and which qualify under the provisions of Section 501(c)(3) of the Code, and which, if practical, are engaged in affairs substantially similar to those of the Corporation, or to the State of Tennessee or any governmental subdivision thereof exclusively for public purposes all as shall be determined by the Board of Directors of the Corporation. In default of any such determination, all remaining assets shall be disposed of by a court of competent jurisdiction in the county in which the principal office of the Corporation is then located exclusively for charitable, scientific, literary, or educational purposes, or to one or more organizations that are organized and operated exclusively for such purposes, as such court determines.

CERTIFICATION

IN WITNESS WHEREOF, these Articles of Incorporation are hereby executed and filed with the Secretary of State of the State of Tennessee, as of September 11, 2015, to be effective immediately.



Claire C. Haltom, Incorporator

Exhibit 8

Interim Parent Company Bylaws

INITIAL/PRE-CLOSING BYLAWS
Monday, October 26, 2015

BYLAWS
OF
NEWCO, INC.

ARTICLE I
NAME, PURPOSE, AND PRINCIPAL PLACE OF BUSINESS

Section 1. Name. The name of this Corporation is Newco, Inc. (hereinafter referred to as the “Corporation”).

Section 2. Purposes. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the “Code”), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. Duties. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation’s subsidiaries. The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

Section 2. Composition. The Corporation’s Board of Directors shall consist of four (4) directors, two (2) of whom shall be appointed by Mountain States Health Alliance, (“MSHA”), and two (2) of whom shall be appointed by Wellmont Health System (“Wellmont”); provided, however, that all Directors shall be persons who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as

described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of MHSA and directors of Wellmont.

Section 3. Terms.

The Directors shall serve for a term of two (2) years commencing immediately following his or her respective appointment and continuing until their respective successors shall have been appointed and qualified.

Section 4. Vacancies. Vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the corporation which appointed the Director vacating the position.

Section 5. Removal. Directors may be removed without cause by the corporation which appointed the Director to be removed.

Section 6. Resignation. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 7. Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such information is oral, written or preserved in any other form. No Director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation.

ARTICLE IV
OFFICERS OF THE CORPORATION

Section 1. Officers. The officers of the Corporation shall consist of a President, a Secretary, and a Treasurer. Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. A duly appointed officer may appoint one (1) or more officers or assistant officers.

Section 2. Resignation. An officer may resign at any time by delivering written notice of resignation to the Corporation's President or Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. President. Subject to the oversight of the Board of Directors, the President of the Corporation shall have general supervision, direction and control of the business and affairs of the Corporation and shall have the general powers and duties of management usually vested in persons in similar positions. In such capacity, the President shall report to the Board of Directors. The President, or his/her designee, may execute all promissory notes, mortgages, deeds, contracts and other instruments. The President shall have such other duties and authority as may be prescribed elsewhere in these Bylaws or from time to time by the Board of Directors.

Section 2. Secretary. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of any committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 3. Treasurer. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI
MISCELLANEOUS

Section 1. Corporate Seal. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. Fiscal Year. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE VII
NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper, in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE VIII
INDEMNIFICATION

Section 1. Indemnification of Officers and Directors. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. Indemnification of Employees and Agents. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. Insurance. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. Nonexclusivity. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. Statutory Immunities. Nothing contained in this Article VIII shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE IX
CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

Exhibit 9

Amended Parent Company Bylaws

FINAL DRAFT

AMENDED AND RESTATED

BYLAWS

OF

NEWCO, INC.

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ARTICLE I
NAME AND PURPOSE.

Section 1. Name. The name of this Corporation is Newco, Inc. (hereinafter referred to as the “Corporation”).

Section 2. Purposes. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Internal Revenue Code of 1986, including any amendments that may be made from time to time (the “Code”), and that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code. The Corporation is organized and will be operated exclusively for charitable, scientific, and educational purposes within the meaning Section 501(c)(3) of the Code, including the business of developing, owning and operating inpatient hospitals, clinics, physician practices, other healthcare services, and other services, businesses and activities for the overall purpose of promoting health and providing quality health care services to a broad cross section of the community. In accomplishment of such purposes, the Corporation shall be organized, and at all times operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of the not for profit corporations of which it is a member, provided that such not for profit corporations (i) qualify at all times as organizations exempt from federal income tax under Section 501(c)(3) of the Code and (ii) are described in Section 509(a)(1) or 509(a)(2) of the Code.

ARTICLE II
MEMBERS

The Corporation shall have no members.

ARTICLE III
BOARD OF DIRECTORS

Section 1. Duties. The business and affairs of the Corporation shall be governed exclusively by its Board of Directors. The Board of Directors shall be responsible for ensuring high quality delivery of health care and human services to the communities served by the Corporation and the Corporation’s subsidiaries, with such responsibilities including, but not being limited to:

(a) the establishment, approval and review of policies necessary for the governance of the Corporation, including delegations of authority, establishment and Board approval of the strategic plan, the provision of quality patient care and the appropriate allocation of personnel, resources and assets;

(b) the establishment, approval and review of policies and procedures, or the appropriate delegation of authority for such policies and procedures, for the effective delivery of healthcare services within the Corporation’s affiliated Hospitals and ancillary facilities including appropriate Medical Staff bylaws and competency standards, nursing practice standards, and regulatory standards for care delivery;

(c) the approval of the Corporation’s annual operating budget;

(d) the approval of long-term capital expenditure budgets which address the Corporation's anticipated capital needs;

(e) the regular review of the Corporation's financial performance vis-a-vis its annual operating budgets and capital budgets, and the adjustment or modification of such budgets from time to time as circumstances require;

(f) the establishment of policies sustaining performance improvement, risk management and quality programs with appropriate assessment of effectiveness of each program;

(g) the regular review of the Corporation's Corporate Compliance Plan, its implementation, and observance;

(h) the oversight of fulfillment of the community benefit purpose of the Corporation;

(i) at the end of the Integration Period, conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

The Board of Directors may delegate certain authorities to subsidiary boards. Any authorities not specifically delegated are reserved to the Board of Directors of the Corporation.

The Board of Directors, in fulfilling its governance role, will ensure meaningful participation by management, clinical and physician leadership and any advisors deemed appropriate by the Board of Directors. The Board of Directors shall require the implementation of such systems and procedures as will foster effective communication by and among the administrative and departmental staffs, the Medical Staffs, and the Board of Directors.

At least one (1) time each fiscal year, the Board of Directors shall meet to assess the performance of the Board of Directors and the Corporation's progress toward executing its strategic plan and achieving its stated goals and objectives. Where appropriate, such review process shall include an assessment and adjustment of the Corporation's long-range, strategic, and operational plans and policies, as well as the Corporation's budget, fiscal position, and allocation of resources, in light of the Corporation's stated business purposes and mission statement.

(j) **Composition (Integration Period)**. During the Integration Period, the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, sixteen (16) of whom shall be appointed on the Closing Date. Two of the voting directors shall be the Executive Chair/President of the Corporation and the Chief Executive Officer of the Corporation, each of whom shall serve as a voting ex-officio director, subject in the case of the Chief Executive Officer, to the limitations in Sections 2 and 3 below. The voting directors who are not serving ex officio shall be and are divided into two (2) Category J Directors, six (6) Category W Directors and six (6) Category M Directors. The voting directors who are not serving ex officio shall be and are divided further into three classes, designated Class I, Class II and Class III. Class I and Class II initially each shall consist of two (2) Category M Directors and two (2) Category W Directors. Class III initially shall consist of two (2) Category J Directors, two (2) Category M Directors, and two (2) Category W Directors. At least two (2) Category M Directors and two (2) Category W Directors shall be physicians who are members of the active medical staff of at least one of the

Corporation's affiliated Hospitals; provided, however, that, at all times, the majority of the Board of Directors shall consist of members who are deemed to be independent community directors in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers; provided, further, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(k) **Composition (Post-Integration Period)**. Except for the purposes of Section 3(b)(ii) below, upon the expiration of the Integration Period the division of the Board of Directors into Categories J, M and W shall cease, but the terms and the designation into Classes of the persons then serving as Directors shall not be affected thereby. After the expiration of the Integration Period the Corporation's Board of Directors shall consist of not more than seventeen (17) voting directors, one of whom shall be the Executive Chair/President of the Corporation who shall serve as a voting ex-officio director. The sixteen (16) voting directors who are not serving ex officio shall be and are divided into three classes, designated: Class I, Class II and Class III; provided, in order to satisfy the requirements for an organization supervised or controlled in connection with organizations described in Code Section 509(a)(1) or (2), as described in Code Section 509(a)(3)(B)(ii), at all times all of the Corporation's directors will also be directors of Mountain States Health Alliance and directors of Wellmont Health System. In addition, the person serving from time to time as the President of East Tennessee State University shall serve as a non-voting ex-officio director.

(l) **Qualifications**. In the selection of directors, appropriate consideration shall be given to an individual's competencies, skills and perspectives and the individual's ability to commit the time necessary to devote to a director's duties. Consideration shall also be given to the inclusion of a variety of business, health-related, and consumer perspectives among the various members of the Board of Directors, with a goal of achieving (i) a geographic and demographic diversity among the members and (ii) a mix of competencies, skills and perspectives as determined by the Board from time to time to be necessary or desirable

(m) **Orientation**. The Board shall adopt a policy ensuring appropriate orientation of new Board and Board Committee members.

(n) **Additional Independent Director**. During the Integration Period, the Board of Directors may choose to elect a person to serve as the Additional Independent Director, who may be in addition to the sixteen (16) persons appointed on the Closing Date. If elected, the Additional Independent Director will be a Category J Director and appointed to Class III.

Section 2. Terms

Generally, each director shall serve for a term of three (3) years ending on the date of the third annual meeting of directors following the annual meeting of directors at which such director was elected. For purposes of this section, the Closing Date shall be deemed the date of the initial annual meeting and initial election of directors. Notwithstanding the generally applicable terms of office, each director initially appointed to Class I shall serve for an initial term expiring at the

Corporation's second annual meeting of directors following the Closing Date; each director initially appointed to Class II shall serve for an initial term expiring at the Corporation's third annual meeting of directors following the Closing Date; and each director initially appointed to Class III (including the Additional Independent Director, if elected) shall serve for an initial term expiring at the Corporation's fourth annual meeting of directors following the Closing Date; provided, that the term of each director shall continue until the election and qualification of a successor and be subject to such director's earlier death, resignation or removal. Ex-officio directors shall serve for a term that is commensurate with their term of office in the ex-officio position which creates membership on the Corporation's Board of Directors, except that the Chief Executive Officer of the Corporation shall cease to serve as a voting ex-officio director on the second anniversary of his or her initial appointment.

Elected directors may serve no more than two (2) consecutive three (3) year terms. An initial appointment as a Class I, Class II, or Class III Director shall be deemed a 3-year term for the purpose of this consecutive term limitation.

Section 3. Vacancies.

(a) In General. Except as set forth in subsection (b) of this Section 3, vacancies arising in positions on the Board of Directors (whether by resignation, death, expiration of term of office, termination, removal, increase in Board size, or other reason) shall be filled by the Board of Directors based upon nominations presented by the Governance/Nominating Committee. In submitting its nominations, the Governance/Nominating Committee shall endeavor to propose nominees who possess the skill sets identified in Article III, Section 1 of these Bylaws taking into account the skill mix of the persons then serving on the Board of Directors.

(b) Integration Period and Initial Vacancies.

(i) During the Integration Period, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the remaining Category M or Category W Directors, as the case may be. During the Integration Period, any vacancy among the Category J Directors, including the Additional Independent Director, if nominated by the Governance/Nominating Committee, shall be filled by a person approved by the vote of a majority of each of the Category M Directors and the Category W Directors, voting as two classes.

(ii) Notwithstanding Section 1(k) above, after the Integration Period, and until the fourth anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, any vacancy among the Category M Directors or Category W Directors shall be filled by a vote of the majority of the Board of Directors upon the nomination of a replacement by the remaining Category M or Category W Directors, as the case may be, and shall consider the appropriate competencies determined to be desirable by the Board of Directors.

(iii) The Category W Directors shall appoint, by majority vote, a person to serve as a Class I, Category W Director to replace the Chief Executive Officer of the Corporation when he or she shall cease to serve as a voting ex-officio director as provided in Section 2 above.

(iv) In the event of a separation between the Corporation and the Executive Chair/President during the Integration Period:

A. The Category M Directors shall nominate one Director to serve as the Acting Chair of the Board of Directors, which nominee shall be subject to election by a majority vote of the Board of Directors. The Acting Chair shall assume the powers and responsibilities of the Executive Chair/President as Chair of the Board of Directors and will not have operating responsibilities.

B. The Chief Executive Officer shall immediately become a non-voting ex-officio director.

C. The Board may choose to appoint an interim President to assume the management responsibilities of the Executive Chair/President. The Board shall follow industry best practices in developing a process for selection of a permanent replacement for the Executive Chair/President.

D. The Board shall conduct a review to determine whether retaining the Executive Chair/President and Vice Chair/Lead Independent Director structure, or converting to an independent Chair and Chief Executive Officer structure, is necessary or desirable in the best interest of the Corporation and its mission and purpose.

Section 4. Removal. Voting and non-voting directors may be removed by a majority vote (as described below in Section 5) of the Board of Directors only for cause. For purposes of these Bylaws, “for cause” shall mean: (i) failure to satisfy the attendance requirements for directors set forth below in Section 7; (ii) continuous disruptive behavior as determined by the Board of Directors in its reasonable judgment; (iii) conviction of a felony or a crime of moral turpitude; (iv) incapacity, inability, or unwillingness to perform the duties and responsibilities of a director, as determined by the Board of Directors in its reasonable discretion; (v) engagement by a director in an activity, arrangement, or transaction which would result in a material conflict with his or her position as a director of the Corporation or the Corporation’s interests or purposes, as determined by the Board of Directors in its reasonable discretion; (vi) a breach of the duty of confidentiality as such duty is set forth below in Section 9, or as such duty may otherwise be provided for or defined from time to time in the Corporation’s internal policies or by action of the Board of Directors, or (vii) such other activity, event, or reason determined to constitute cause by the Board of Directors in its reasonable discretion.

Section 5. Actions of the Board.

(a) **Majority and Super-Majority Votes.** Except as otherwise set forth below, actions of the Board of Directors shall require the affirmative vote of a majority of the voting directors at a meeting at which a quorum is present. For purposes of these Bylaws, a quorum of the Board of Directors shall be a majority of the voting directors. Notwithstanding the foregoing, until the second anniversary of the closing of the affiliation transaction between Wellmont Health System and Mountain States Health Alliance, the following actions may be taken by the Board of Directors only upon the affirmative vote of a majority of the directors then in office, which must include a majority of the Category M Directors and a majority of the Category W Directors, each voting as a class (referred to herein as a “super-majority vote”):

(i) Amendments to the Charter or Bylaws of the Corporation, including amendments to the duties of the Executive Chair/President or the Vice Chair/Lead Independent Director as set forth in these Bylaws.

(ii) Sale or closure of any of the Hospitals;

(iii) Adoption of a plan of dissolution for the Corporation;

(iv) Sale or other transfer of all or substantially all of the Corporation's assets;

(v) Entering into a plan of merger or consolidation of the Corporation with or into an unrelated entity;

(vi) Incurrence of any indebtedness, guarantees, or capital lease obligations exceeding \$100 million in the aggregate during any fiscal year, other than trade payables and other short-term liabilities in the ordinary course of business;

(vii) Discontinuation of major service lines where any such discontinuation would render the service unavailable in that community.

(viii) Any decision to file a petition requesting or consenting to an order for relief under the federal bankruptcy laws, or other actions with respect to the Corporation or any member of its obligated group as a result of insolvency or the inability to pay debts generally as such debts become due.

Section 6. Meetings. The Board of Directors shall hold an annual meeting in the month of June of each year. The Board shall hold regular meetings on not less than a quarterly basis. Special meetings shall be held as called by the Executive Chair/President or the Vice Chair/Lead Independent Director, or as requested by any three (3) directors in writing to the Secretary of the Corporation. Any actions of the Board of Directors to be taken at a meeting may be taken without a meeting if all voting directors consent in writing (which shall include electronic mail) to taking such action without a meeting. Directors may participate in any meeting of the Board of Directors by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting.

Section 7. Attendance Requirements. Each voting director shall be required to attend at least seventy-five percent (75%) of all scheduled meetings during any fiscal year (annual, regular, or special), unless otherwise excused by the Executive Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or failure to attend three (3) consecutive meetings shall constitute cause for removal as a voting director.

Section 8. Resignation. A director may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

Section 9. Confidentiality and Fiduciary Duty of Loyalty, Care and Obedience. Each director shall maintain the strict confidentiality of all information discussed or received in connection with any meeting of the Board of Directors and any committee meeting, whether such

information is oral, written or preserved in any other form. Unless otherwise expressly authorized by Board action or by the Executive Chair/President, or unless disclosure is otherwise made by the Corporation through authorized action such as approved press releases or public statements, no director shall disclose, discuss or otherwise disseminate any information relating to the actions, deliberations and decisions of the Board of Directors and any committee of the Board of Directors. In any situation where comment or discussion is permitted, such comment or discussion shall extend only so far as is consistent with the degree of authorization. Further, no director shall use any information gained through or in connection with his or her capacity as a director in any manner which might create, directly or indirectly, any form of personal benefit unless such usage is consistent with and done in compliance with the Corporation's policies regarding Conflicts of Interest. Each Director shall, at all times, exercise loyalty, care and obedience to the fiduciary responsibilities entrusted to the Director on behalf of the Corporation. Each director shall execute an annual written acknowledgement of his or her duties of confidentiality, loyalty, care and obedience and such acknowledgements shall be kept in the official records of the Corporation.

ARTICLE IV **OFFICERS OF THE CORPORATION**

Section 1. Officers. The officers of the Corporation shall consist of an Executive Chair/President, a Vice Chair/Lead Independent Director, a Chief Executive Officer (the "CEO"), a Secretary, a Treasurer, and such officers as the Board of Directors shall elect or appoint. The offices of Executive Chair/President, Vice Chair/Lead Independent Director, Secretary, and Treasurer shall be held by directors (collectively, the "Board Officers").

Section 2. Terms of Office. Except for the Executive Chair/President and the CEO, who shall each hold their offices for so long as their employment by the Corporation to serve in those positions continues, the Board Officers shall serve two (2) year terms. A Board Officer may serve no more than two (2) consecutive two (2) year terms in the same office. Nothing contained in these Bylaws shall be construed to constitute a contract of employment. Other than the limitations applicable to Board Officers, there shall be no limit as to the number of consecutive terms corporate officers may serve. Each Board officer shall hold office until his or her successor is duly elected and qualified.

Section 3. Election, Removal and Vacancies.

(a) Except as provided below, all officers of the Corporation shall be elected by, and shall serve at the pleasure of, the Board of Directors. Nominations for Board Officer positions shall be submitted by the Governance/Nominating Committee. Nominees for Board Officer positions shall be Directors. Removal of any officer shall be without prejudice to the contract rights, if any, of the officer; provided, however, that election of an officer itself shall not create any contractual rights.

(b) During the Integration Period, the successor to the person serving as the initial Vice Chair/Lead Independent Director shall be nominated by a majority vote of the Category W Directors, and elected by the non-management members of the Board of Directors. The individuals elected to serve as Treasurer and Secretary during the Integration Period shall be elected as follows: one from among the Category W members and one from the Category M members.

Section 4. Resignation. An officer may resign at any time by delivering written notice of resignation to the Corporation's Secretary. Resignation is effective when the notice is delivered unless the notice specifies a later effective date, in which case such date shall be the effective date.

ARTICLE V
POWERS AND DUTIES OF THE OFFICERS.

Section 1. Executive Chair/President. The Executive Chair/President shall have the powers usually vested in the office of Chair of a Board of Directors, the powers usually vested in the office of President of a Corporation, and as the most senior officer of the Corporation, shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Executive Chair/President and any amendments thereto. He or she shall preside at all meetings of the Board of Directors, unless he or she is unable to attend. He or she shall see that all orders and resolutions of the Board of Directors are carried into effect. He or she shall perform all other duties required of him or her by the laws of the State of Tennessee. The Board of Directors shall periodically evaluate the performance of the Executive Chair/President in the context of the Corporation's progress toward and attainment of the Corporation's strategic and business goals and objectives as established from time to time by the Board. The Executive Committee, or another committee specifically appointed by the Board, shall conduct such performance reviews. The Executive Chair/President shall, at least annually, evaluate the performance of the CEO and the other officers reporting to him or her.

Section 2. Vice Chair/Lead Independent Director. In the absence or disability of the Executive Chair/President, the Vice Chair/Lead Independent Director shall exercise only those powers and shall perform only the duties of the Executive Chair/President with respect to the Executive Chair/President's role as the Chair of the Board of Directors, and not any of the powers and duties of the Executive Chair/President as the President and most senior officer the Corporation. Additionally, he or she shall have the duties set forth in Exhibit A attached hereto.

Section 3. Chief Executive Officer. The Chief Executive Officer (the "CEO") shall be appointed by Executive Chair/President. Any employment agreement with respect to the CEO shall be ratified by a majority vote of the Board of Directors. The Chief Executive Officer will report to the Executive Chair/President and shall have the powers and duties set forth in the written employment agreement entered into by the Corporation with the Chief Executive Officer and any amendments thereto. The CEO shall, at least annually, evaluate the performance of the officers reporting to him or her.

Section 4. Vice Presidents. To the extent any Vice President is to act as an officer of the Corporation, the Board of Directors shall confirm such responsibilities as an officer of the Corporation through resolution or other form of approval. Each such Vice President shall be responsible for executing and carrying out such duties, instructions, objectives and orders as may be established by the Executive Chair/President or CEO from time to time.

Section 5. Secretary. The Secretary shall cause to be kept the minutes of all meetings of the Board of Directors and of the Executive Committee. He or she shall cause to be given all notices provided for in these Bylaws. He or she shall have custody of the seal of the Corporation and shall affix the same, attested by his or her signature, to all instruments required to be under the seal of the Corporation. He or she shall have the duties, power and responsibilities of the secretary

of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

Section 6. Treasurer. The Treasurer shall be the official custodian of all funds and securities of the Corporation, and shall deposit, or cause to be deposited, same in such banks or other depositories as the Board of Directors may designate or approve. He or she shall have the duties, power and responsibilities of the treasurer of a Corporation under the laws of the State of Tennessee and shall perform such other duties as may be prescribed by the Board of Directors.

ARTICLE VI

SIGNATURE AND ENDORSEMENTS OF NOTES, CHECKS, ETC.

Section 1. Signatures. All notes, checks, bonds, and other promises to pay money shall be signed by an officer or other individual authorized by the Board of Directors.

Section 2. Endorsements and Sales of Securities. Checks, drafts, notes, and other negotiable instruments payable to the Corporation or to its order shall be endorsed for collection or deposit by an officer or other individual authorized by the Board of Directors. Stocks, bonds, or other securities owned by the Corporation may be sold or transferred upon signature of an officer or other individual authorized by the Board of Directors.

ARTICLE VII

COMMITTEES

Section 1. Designation. The Board of Directors may, from time to time, establish such standing and special committees as it deems advisable and in the best interests of the Corporation. All committee actions are advisory to the Board of Directors, unless the Board of Directors, through resolution, has delegated any authority to a committee it deems advisable; provided, however, that no committee may:

- (a) Take any action required by Article III, Section 6, to be taken by a super-majority vote of the Board of Directors;
- (b) Authorize distributions; or
- (c) Elect, appoint, or remove directors or fill vacancies on the Board of Directors or any committee thereof.

Section 2. Committee Members. Other than members of the Executive Committee, whose members shall be members of the Board of Directors, Board committees may be composed of non-directors. Members of a committee may be designated as voting or non-voting ex-officio members. The Executive Chair/President shall recommend committee members, and presiding officers/chairs, for standing committees annually for consideration by the Governance/Nominating Committee. The Governance/Nominating Committee shall consider the recommendations of the Executive Chair/President, and make nominations to the Board of Directors, which shall, by majority vote, elect the committee membership. Each committee member shall serve for a one (1) year term, or on such other basis and for such other terms as set forth by the Board of Directors. The Board of Directors may remove any committee member with or without cause. Vacancies on a committee, due to death, resignation, expiration of term, or removal shall be filled by the Board of

Directors in the manner prescribed in this section. Committee members shall serve until their successors are duly elected and qualified. For the initial committee appointments, the Governance/Nominating Committee shall ensure equal numbers of individuals from existing committees of the Boards of Directors of Wellmont Health Systems and Mountain States Health Alliance. For purposes of this section, initial committee appointments shall mean only the first appointment of the individual selected to serve upon the Closing Date and shall not apply to any vacancies thereafter.

Section 3. Voting and Quorum Requirements. Except as otherwise limited by the Board of Directors, all actions of a committee shall require the affirmative vote of a majority of the voting members of the committee at a meeting at which a quorum is present. A majority of the voting members shall constitute a quorum. Any actions of a committee to be taken at a meeting may be taken without a meeting if all voting members of the committee consent in writing, to include electronic mail, to taking such action without a meeting. Members may participate in any meeting of the Committee by means of a conference telephone or similar communications equipment through which all persons participating in the meeting can hear each other. Participation by such means shall constitute presence in person at such meeting. Each Committee shall hold such meetings as it deems appropriate, or as directed by the Board. Each Committee member shall be required to attend seventy-five percent (75%) of all scheduled meetings (regular or special) during any fiscal year, unless otherwise excused by the chair of the Committee. Failure to attend seventy-five percent (75%) of all scheduled meetings or three (3) consecutive scheduled meetings shall constitute cause for removal as a member of such Committee.

Section 4. Standing Committees. The Corporation's Board of Directors shall have the following standing committees: Executive; Audit and Compliance; Finance; Quality, Service and Safety, Executive Compensation, Community Benefit, Workforce and Governance/Nominating. The Board of Directors may establish such other committees as it deems necessary or appropriate from time to time. Committee Chairs shall be members of the Board of Directors. The Executive Chair/President and CEO may not serve as Chair of standing committees, except that as provided in subsection (a)(i) below the Executive Chair/President shall serve as the presiding officer of the Executive Committee. Non-voting ex-officio members may serve as Committee Chairs upon the conclusion of the Integration Period. Each standing committee and any committee created by the Board of Directors shall establish and maintain a charter describing its duties in detail, shall regularly review and propose revisions to its charter in light of industry best practices, and shall present such charter and any proposed revisions for review and approval by the Board of Directors.

(a) **Executive Committee.**

(i) **Composition.** The Executive Committee shall be comprised of both voting and non-voting members. The voting members shall be the Executive Chair/President, the Vice Chair/Lead Independent Director, the Treasurer, and the Secretary of the Corporation, and two at-large members. The CEO of the Corporation shall be a non-voting ex-officio member of the Executive Committee. The Executive Chair/President shall serve as the presiding officer of the Executive Committee. The initial at-large members of the Executive Committee serving during the Integration Period shall be one Class W Director and one Class M Director.

(ii) **Powers and Duties.** The Executive Committee shall have and exercise the full authority and have all the powers and duties of the Board of Directors except as otherwise limited by the Act, the Board of Directors, or these Bylaws. The Executive Committee may

transact the business of the Corporation in urgent situations during the periods between meetings of the Board of Directors; provided that any action taken shall not conflict with the policies and expressed wishes of the Board of Directors. Matters of major importance shall be referred to the entire Board of Directors unless the urgency of the situation does not permit delay. The Executive Committee shall report any action taken between meetings to the Board of Directors as soon as practicable.

(iii) **Review of Executive Chair/President.** The Executive Committee, or another committee as expressly determined by the Board of Directors, is charged with the responsibility of evaluating the Executive Chair/President. The Executive Compensation Committee shall be charged with the responsibility of approving the compensation of the Executive Chair/President. The Executive Committee shall provide its evaluation of the Executive Chair/President to the Executive Compensation Committee for its consideration, in addition to any other factors considered by the latter, in setting compensation of the Executive Chair/President. The Lead Independent Director shall ensure a mechanism is established for input by the full Board of Directors on the evaluation of the Executive Chair/President, and that feedback is provided to the Executive Chair/President. As it relates to his or her compensation or performance evaluation, the Executive Chair/President shall not participate in the evaluative deliberations of the Executive Committee or the Executive Compensation Committee other than to provide information, answer questions and receive feedback.

(b) **Audit and Compliance Committee.** The Audit and Compliance Committee shall:
(a) ensure the integrity of the Corporation's financial reporting and audit procedures, including engagement of an independent public accounting firm to conduct an annual certified audit and examination of the Corporation's financial reporting and controls; (b) ensure financial controls are adequate to protect the integrity of the Corporation's financial assets; (c) report, as needed, to the Board of Directors, any issues related to financial controls and recommend any changes deemed necessary by the committee; (d) monitor the Corporation's compliance program and make any recommendations related to compliance risk and (e) approve the compliance policies. The Corporation's Chief Compliance Officer and Senior Audit Director shall report jointly to the Executive Chair/President and to the Audit and Compliance Committee, and any reports shall be provided to both. The Audit Committee shall be comprised of membership that includes individuals with audit and public accounting experience. The Governance/Nominating Committee shall seek to nominate a Chair of the Audit and Compliance Committee who is experienced in accounting and audit oversight, subject to the requirement that committee chairs must be members of the Board of Directors. The membership of the Audit and Compliance Committee shall be constituted by individuals who are independent as defined by the IRS Form 990.

(c) **Finance Committee.** The primary responsibilities of the Finance Committee are to develop and recommend operating and capital budgets to the Board of Directors, and to monitor the ongoing financial performance of the Corporation.

(d) **Quality, Service and Safety Committee.**

(i) The Board of Directors has the ultimate responsibility for quality patient care and authority for maintaining a Performance Improvement and Risk Management Program. The Board of Directors may delegate certain functions of this program to the Executive Chair/President, or to the respective community boards of each hospital (the "Community Boards"), together with the authority for action under limitations described in this section. The Quality, Service and Safety

Committee is charged with the responsibility of ensuring these functions are administered, and reporting to the Board of Directors.

A. The Quality, Service and Safety Committee shall require the medical staffs and staffs of the various departments/services of the hospitals to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care.

B. The Board of Directors, through the Quality, Service and Safety Committee, the Executive Chair/President and CEO, shall fully support performance improvement activities and mechanisms. The Board, through the Executive Chair/President, shall also provide for adequate resources and support systems for the performance improvement functions related to patient care and safety.

C. The Quality, Service and Safety Committee shall assess the effectiveness of the performance improvement program on an annual basis, and shall re-endorse or recommend revisions to the program as necessary. These recommendations shall be made to the Board of Directors, which shall timely consider the recommendations, and either endorse or make changes to the program.

(ii) The Medical Staffs of the various affiliated hospitals, through their elected officers, departments, committees, and individual members shall make a commitment to actively participate in the performance improvement program by developing indicators to be used for screening, evaluating and utilizing clinical judgment concerning identified problems or opportunities to improve care. Findings shall be reported to the Board of Directors through the Quality, Service and Safety Committee. Priority shall be given to those aspects of care which are high-volume, high-risk or problem-prone.

A. Department Chairmen are responsible for assuring the implementation of a planned and systemic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the departments and the clinical performance of all individuals with clinical privileges in those departments. When important problems in patient care and clinical performance or opportunities to improve care are identified, action shall be taken and the effectiveness of such action taken evaluated.

B. The presidents of the respective medical staffs shall facilitate and coordinate medical staff involvement in the performance improvement program and shall serve as advisor to the respective Community Board on performance improvement matters.

C. The respective Community Boards may delegate oversight of the hospital-wide performance improvement program as it pertains to the medical staff to the executive committee of the medical staff.

(iii) The Executive Chair/President, through the CEO, is responsible for implementation of the performance improvement program as it concerns non-physician professionals and technical staff and patient care units. The Executive Chair/President shall actively support the performance improvement program by the provision of adequate resources.

(iv) The Executive Chair/President may delegate necessary functions to the CEO to ensure, system-wide, that all functions related to performance improvement, risk management and improvement in the clinical aspects of care are prioritized, performed, and that relevant information about the effectiveness of these functions is reported to the Quality, Service and Safety Committee.

(v) At all times during the Integration Period, the Chair of the Quality, Service and Safety Committee shall be a physician member of the Board of the Corporation.

(e) **Executive Compensation.** The Executive Compensation Committee shall be composed of members who are independent in accordance with Internal Revenue Service guidance for organizations that are exempt from federal income tax under Code Section 501(c)(3) and which provide hospital services or other health care services or serve as supporting organizations to tax exempt health care services providers. The Committee shall evaluate and approve compensation, and changes to compensation, for the Executive Chair/President. The Committee shall consider and approve the compensation for the Chief Executive Officer, any executive vice president or senior vice president based upon the recommendation of the Executive Chair/President. Evaluations by the Executive Chair/President or CEO of the performance of any executive vice president or senior vice president shall be made available if requested by the Executive Compensation Committee for its use in consideration of the recommended adjustment to compensation. In evaluating compensation, the committee shall satisfy the Rebuttable Presumption of Reasonableness standards as promulgated by the Internal Revenue Service as amended from time to time.

(f) **Community Benefit and Population Health.** The Community Benefit Committee's responsibilities shall include: (1) extending and strengthening the Corporation's community benefit programs and services, (2) review community benefit strategies and performance to assure adequate financial and human investments are maintained, (3) monitor the community benefit reporting to ensure integrity of the information, (4) ensure compliance with community benefit standards imposed by regulatory agencies, (5) ensure public recognition of community benefit activities and community value through periodic reports to the community, (6) review of population health initiatives, and (7) oversight of compliance by the Corporation with the terms of any Certificate of Public Advantage to which the Corporation is subject. The committee shall report its findings and recommendations to the Board.

(g) **Governance/Nominating Committee.**

(i) The Governance/Nominating Committee shall be responsible for ensuring there is an effective process for filling board and committee positions, and that timely recommendations are made for the Board of Directors to consider. This committee shall also consider, from time to time, issues of governance, including review of bylaws, rules, and regulations, and establishing governance goals. The Governance/Nominating Committee shall also consider and recommend education and other resources for enhancement of Board performance, and shall lead the annual Board self-evaluation. The Executive Chair/President shall be an ex-officio member of the Governance/Nominating committee. Upon the creation of vacancies on the Board or on committees of the Board, the Executive Chair/President shall collaborate with the members of the

Board of Directors to facilitate recommendations to the Governance/Nominating Committee for consideration. The Executive Chair/President shall not vote on matters relating to nominations, but may vote on governance matters.

(ii) At its discretion, the Governance/Nominating Committee shall evaluate the advisability of adding to the Board of Directors one additional voting director, who, among other qualifications as determined by the Governance/Nominating Committee, shall (i) be a nationally recognized, independent health care expert, (ii) not residing in the Northeast Tennessee or Southwest Virginia region, (iii) who provides incremental value to the Board of Directors through competencies or relationships not then available to the Board of Directors, and (iv) who has not been previously engaged by or with Wellmont Health System or Mountain States Health Alliance nor has been involved in a financial, business, investment or family relationship with the Executive Chairman/President or CEO of the health system (the “Additional Independent Director”). If the Governance/Nominating Committee determines that the Additional Independent Director is advisable, it shall undertake a search process to fill that position whose nomination the Governance/Nominating Committee is prepared to submit to the Board of Directors.

(h) **Workforce Committee.** The Workforce Committee shall provide recommendations to the Board of Directors on matters relating to the workforce of the Corporation, including, but not limited to, matters relating to: (1) implementation of workforce plans for recruitment and retention, (2) policies which support the workforce plan, (3) education and professional development of the clinical workforce, (4) competence of the workforce, (5) policies and practices related to a safe and productive workplace, (6) benefits, and (7) any opportunities related to the facilities of the Corporation becoming and remaining the health care workplace of choice.

Section 5. Clinical Council. A physician-led clinical council will be maintained, composed of independent, privately practicing physicians as well as physicians employed by the Corporation or its subsidiaries or affiliates. The Clinical Council will include representatives of management, but the majority will be composed by physicians. The Clinical Council will report to the Chief Medical Officer of the Corporation, or to the senior officer of the Corporation if there is no Chief Medical Officer. The Chair of the Clinical Counsel will be a physician member of the active medical staff(s) of one or more affiliated hospitals, will serve on the Quality, Service and Safety Committee of the Board, and will provide ongoing reports on the activities of the Clinical Council to the Board through the Quality, Service and Safety Committee of the Board. Among other duties assigned to it from time to time, the Clinical Council will endeavor to establish a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards. The Clinical Council will provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors. The Clinical Council members serve at the pleasure of the Board of Directors and may be removed with or without cause.

ARTICLE VIII

MEMBER CORPORATION BOARDS

Section 1. Appointment. The Corporation is the sole member of Mountain States Health Alliance and Wellmont Health System (the “Subsidiary Corporations”). The Corporation’s Board of Directors shall also serve as the Board of Directors of each of the Subsidiary Corporations pursuant to the Amended and Restated Bylaws of each Subsidiary Corporation.

Section 2. Delegation of Authority. Subject to limitations prescribed exclusively by the Board of Directors, the board of directors of each Subsidiary Corporation shall perform the following duties: (i) oversee the relationship of each Hospital owned by the Subsidiary Corporation with its physicians and other medical providers, including administration of the credentialing and disciplinary process applicable to such Hospital's medical staff, (ii) assure compliance by the Hospitals owned by the Subsidiary Corporation with the accreditation standards promulgated by the Joint Commission, and (iii) govern the business and affairs of the Subsidiary Corporation, subject to the limitations set forth in these bylaws and the Articles of Incorporation the Subsidiary Corporation. The board of directors of each Subsidiary Corporation shall provide reports to the Board of Directors regarding actions taken pursuant to the delegation of duties specified above in a manner prescribed by the Board of Directors. The board of directors of each Subsidiary Corporation is authorized to exercise the powers, authority and responsibilities set forth in this Section 2 pursuant to this delegation by the Board of Directors of the Corporation. Any powers not specifically delegated in this Section 2 are reserved to the Board of Directors of the Corporation.

ARTICLE IX MISCELLANEOUS

Section 1. Corporate Seal. The Board of Directors may provide a seal for the Corporation in the form approved by the Board of Directors.

Section 2. Fiscal Year. The fiscal year of the Corporation shall begin on the first day of July of each year.

ARTICLE X NOTICE

Whenever under the provisions of the Act, the Charter, or these Bylaws notice is required to be given to any director, officer, or committee member of the Corporation, it shall not be construed to require personal notice, but such notice, unless required to be in writing, may be given by telephone or electronic mail and, if given in writing, may be given either personally or by facsimile, or by depositing the same in a post office or letter box in a postpaid, sealed wrapper., in either case addressed to such director, officer, or committee member at his or her address as the same appears in the records of the Corporation; and the time when the same shall be so mailed or faxed, shall be deemed to be the time of the giving of such notice.

ARTICLE XI INDEMNIFICATION

Section 1. Indemnification of Officers and Directors. The Corporation shall indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an officer or director (whether voting or non-voting) of the Corporation, including a director of a Hospital Board, against liabilities and expenses incurred in the proceeding to the fullest extent permitted by the Act. The Corporation shall make advances for expenses incurred or to be incurred in the proceeding as provided for in the Act.

Section 2. Indemnification of Employees and Agents. The Corporation may indemnify an individual made a party to a proceeding, criminal or civil, because he or she is or was an employee or agent of the Corporation against liabilities and expenses incurred in the proceeding

to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act. The Corporation may make advances for expenses incurred or to be incurred in the proceeding to the extent determined appropriate by the Board of Directors consistent with the provisions of the Act.

Section 3. Insurance. The Corporation shall have the power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the Corporation (including a director of a Hospital Board), or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust, or other enterprise, against any liability asserted against him or her and incurred by him or her in any such capacity, or arising out of his or her status as such, whether or not the Corporation would have the power or would be required to indemnify him or her against such liability under the provisions of this Article.

Section 4. Nonexclusivity. The rights of indemnification and advancement of expenses granted pursuant to this Article shall not be deemed exclusive of any other rights to which an officer, director, employee, or agent seeking indemnification or advancement of expenses may be entitled, pursuant to the Act, Tennessee statutory or case law, the Corporation's Charter, these Bylaws, a resolution of the Board of Directors, or an agreement or arrangement providing for indemnification; provided, however, that no indemnification may be made to or on behalf of any officer, director, employee, or agent, if a judgment or other final adjudication establishes that such indemnification is prohibited by Section 48-58-502 of the Act or any successor statutory provision.

Section 5. Statutory Immunities. Nothing contained in this Article X shall be construed to prejudice or otherwise diminish the limitations, immunities and other protections available to the directors and officers of the Corporation (including a director of a Hospital Board) pursuant to Section 48-58-601 of the Act or any successor statutory provision.

ARTICLE XII CONFLICTS OF INTEREST

The Board of Directors shall adopt and maintain a Conflict of Interest Policy applicable to all members of the Board, Board Committees, Officers of the Corporation, and key management personnel. The policy shall require the annual completion and submission of an acknowledgement and disclosure statement, as well as a confidentiality agreement applicable to all business of the Board of Directors.

ARTICLE XIII VOLUNTEER AND AUXILIARY ORGANIZATIONS

Volunteer and Auxiliary organizations may, with the approval of the Board of Directors of the Corporation, perform nonprofessional services within the affiliated entities which further the purposes and interests of the Corporation. Such volunteer organizations, in discharging their functions, shall cooperate closely with management of the affiliated entity and the Board of Directors or its designee. Such cooperation may include a requirement for production of reports or information relevant to the services and benefit being provided. The activities of the volunteer or auxiliary organizations shall, if the Corporation's Board of Directors deems proper and necessary, be carried out under bylaws adopted by such organizations, and such bylaws and any amendments thereto shall be subject to revision by, and approval of, the Board of Directors or its designee. The

Board of Directors may require Board of Directors approval of appointments to the Board of any Volunteer or Auxiliary Organization.

ARTICLE XIV **AMENDMENTS**

Section 1. Periodic Review of Bylaws. The Board of Directors shall cause these Bylaws to be reviewed annually to determine whether any amendments or revisions are necessary or desirable from a legal, regulatory or operational standpoint when considered in light of best industry or nonprofit organization practices. The Governance/Nominating Committee shall conduct such review and make recommendations to the Board of Directors..

Section 2. Amendments. Subject to Article III, Section 5 above, these Bylaws may be altered, amended, or repealed, and new Bylaws may be adopted, by the Board of Directors at any meeting, whether annual, regular, or special, by a majority vote of the voting directors serving on the Board of Directors. A full statement of the proposed amendment, or amendments, to these Bylaws shall be set forth in the notice of each such meeting.

ARTICLE XV **DEFINITIONS**

For purposes of these Bylaws, the following terms shall have the following meanings:

“Category J Directors” means those directors initially appointed jointly by Mountain States Health Alliance and Wellmont Health System pursuant to the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016, by and between Wellmont Health System and Mountain States Health Alliance (the “Affiliation Agreement”), and their successors as appointed in accordance with the Bylaws of the Corporation.

“Category M Directors” means those directors initially appointed by Mountain States Health Alliance pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

“Category W Directors” means those directors initially appointed by Wellmont Health System pursuant to the Affiliation Agreement, and their successors as appointed in accordance with the Bylaws of the Corporation.

“Closing Date” means of the closing date pursuant to the Affiliation Agreement.

“Integration Period” means the period beginning on the Closing Date and ending on the second anniversary of the Closing Date.

Exhibit A

Description of the Vice Chair/Lead Independent Director Position

Charter of the Vice Chair/Lead Independent Director

The Vice Chair/Lead Independent Director coordinates the activities of the other non-management Directors, and performs such other duties and responsibilities as the Board of Directors may determine.

The specific responsibilities of the Vice Chair/Lead Independent Director are as follows:

Presides at Executive Sessions

- Presides at all meetings of the Board at which the Executive Chair/President is not present, including executive sessions of the independent Directors.

Calls Meetings of Independent Directors

- Has the authority to call meetings of the independent Directors.

Conducts Evaluation of Executive Chair/President

- Ensures the Executive Committee, or another committee as determined by the Board, conducts an annual review of the performance of the Executive Chair/President, with such review being approved by the non-management members of the Board of Directors.
- Ensures annual compensation review of the Executive Chair/President by the Executive Compensation Committee upon the completion of the annual performance review of the Executive Chair/President.

Functions as Liaison with the Executive Chair/President

- Serves as liaison between the independent Directors and the Executive Chair/President.

Approves appropriate provision of information to the Board such as board meeting agendas and schedules

- Approves meeting information sent to the Board relating to agendas and actions items, including the quality, quantity and timeliness of such information.
- Setting the Board's approval of the number and frequency of Board meetings, and approves meeting schedules to assure that there is sufficient time for discussion of all agenda items.

Authorizes Retention of Outside Advisors and Consultants

- Authorizes the retention of outside advisors and consultants who report directly to the Board of Directors on board-wide issues upon approval of the Governance Committee.

Exhibit 10

Benefits and Potential Disadvantages that may Result from the Cooperative Agreement

Exhibit 10

Benefits and Potential Disadvantages

The proposed transaction involves several key features that differentiate the assessment of its overall advantages and disadvantages from a more traditional hospital merger. These include:

- The specific geography, which is largely rural, and the population served, including their current and anticipated health needs. Population growth in many of the rural communities has been negative,¹ and projections demonstrate flat-to-no population growth against a backdrop of significant downward pressure on inpatient utilization. In many rural hospitals, where the census is below 30, this is a substantial threat to viability under the status quo environment;
- The implications of those health needs on the economic vitality and sustainability of the workforce and competitiveness of the region for Tennessee and more generally; and the overall economic health and wellbeing of the communities in eastern Tennessee;
- The resources and assets needed to efficiently and effectively meet health needs of this diverse population, including the uninsured, Medicaid, Medicare, and commercial populations, now and in the future. Assets and resources include physicians, clinics, outpatient facilities, and inpatient hospital facilities, and the alignment and location of the right assets and resources in the best locations to serve the population;
- The current configuration of the healthcare delivery systems in the area as compared to the efficient and effective configuration of delivery systems – by type of facility and also integration across facilities;
- The supporting infrastructure and investments to manage and improve population health, clinical services, care delivery, and services to improve patient experience and care, outcomes, and address needed priorities at lower and sustainable costs; examples include physician leadership and best practices, clinical coordination and integration, and IT/EHR capabilities across the area and care locations;
- Alignment of the healthcare delivery systems with new payment models and metrics and with payers to establish contracts and methods that seek improved outcomes, access, and reduced costs – increasingly, payers seek contracts with better measures of reduced total medical costs and improved outcomes, not just lower unit prices;
- The likely alternatives to the proposed transaction, including status quo and alternatives;
- The context in which the transaction occurs – namely, a COPA model with specific commitments, conditions, and requirements of the Parties with active supervision by the State.

How do these features differentiate the merger review of the advantages and disadvantages of the proposed transaction from a more traditional merger?

A traditional merger review tends to focus on the predicted and likely effect of the proposed transaction on prices facing commercial health plans and whether these effects are likely to be anticompetitive. The expected benefits of the transaction are often examined with regard to expected merger-specific cost reductions (efficiencies) and gains from realignment of inpatient hospital resources/services, including some consideration of expected quality effects. Costs and benefits have traditionally been evaluated with regard to the implications of predicted prices or

¹ See United States Census Bureau Statistics for County Population, percent change - April 1, 2010 to July 1, 2015, available at: <http://www.census.gov/quickfacts/table/PST045215/00>.

quality effects on patient populations, payers, and/or employers based on future medical costs of inpatient services and their impact on premiums, co-pays and deductibles. The analyses are typically predicated on models that assume that the current marketplace *is at a competitive equilibrium* and that, but-for the merger, competition between two or more independent health systems for commercial contracts would achieve lower prices and higher quality. Generally, these analyses assume away any need for transformational or substantial change in the organization of care delivery by providers and that the assessment of competitive effects on commercial payers can largely be conducted without reference to Medicaid, Medicare, or uninsured populations.

The COPA context is fundamentally different, and the features of this transaction and of the geographic region set out above yield a substantially different advantages/disadvantages calculation for the proposed transaction. Briefly, some of those differences include:

- *Transactions subject to COPA, including this transaction, are a unique set.* They fundamentally involve transactions with major systemic risks to the healthcare delivery system and the merging hospitals, the communities, and the population if they *do not* proceed. These systemic risks and the associated weight of public advantages created are balanced with some antitrust risks under a permitted merger and further mitigated through active supervision by the state. COPA transactions are very likely to include those where the “but-for” world – the world without the proposed transaction or with alternative purchasers -- reduces the potential antitrust risks yet yields very limited, if any, gains or may even yield a substantial reduction in benefits relative to the status quo. For example, in this case, the proposed transaction occurs in an area with multiple challenges and where sustainable competition between two large independent systems is not the most efficient or highest value outcome.
- *The implication is that COPA analysis weighs heavily the collective advantages of the transaction, the collective disadvantages, the practicality of the alternatives to the transaction, and the particular means to assure that the known advantages are achieved and known disadvantages are mitigated or limited substantially by the benefits.*
- *The transaction addresses all populations across all communities.* The benefits to be achieved in terms of enhanced access, reduced costs, improved patient and population experience, quality and outcomes adhere to far more than commercially insured populations. The COPA context values very highly the gains to all populations, patients and residents, from the transaction and not just commercially insured patients – measures of the advantages of the transaction include broader populations, longer term benefits, and improved care and experience across the area, rather than narrower evaluation of specific commercial populations with shorter term quality or price effects.
- *The COPA context provides for the translation of cost-savings and efficiencies into specific commitments, resources and investments to be made by the Parties.* This provides the incentive to achieve the savings, not otherwise likely to occur, and to commit specific resources in specific ways to benefit the overall community and population health. This provides the opportunity for the specific commitments and investments to be directly aligned with community priorities and needs (e.g., investments in new clinics, in new services, in specific population health initiatives) with metrics and methods for reporting and tracking. Investments may also include expedited and area-wide or system-wide clinical initiatives, infrastructure and alignment of care that are part of the commitments made to integrate and align the two competing systems
- *The COPA context provides for mechanisms to keep pricing within a competitive range, using market-based methods that rely on known contracting mechanisms; and contracting terms and*

conditions that might be derived from competition. The COPA essentially provides an enforceable mechanism to ensure that pricing under negotiated agreements will change at a rate not to exceed the upper limits of what might occur in the absence of the transaction.

This section addresses how the proposed transaction between Wellmont and Mountain States – when evaluated with this broader and more appropriate COPA-specific advantage/disadvantage framework – results in material and measurable benefits that far outweigh potential disadvantages.

Benefits of the Proposed Merger

In evaluating the potential benefits of a cooperative agreement, the department shall consider whether the following benefits may result from the cooperative agreement:

(A) Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens;

Situation: Steadily increasing financial pressures on Wellmont and Mountain States require ever-increasing efficiency in order to maintain the excellent level of care historically provided by both systems. Under the proposed merger, the New Health System will be significantly better equipped to deliver enhanced services and improve the overall quality of health care through a fully integrated system of care that utilizes a common clinical IT platform, a regional health information exchange, a system-wide clinical council, and enhanced quality reporting.

Background: As noted in the Application, the two health systems currently have expensive, duplicative healthcare resources that are allocated inefficiently. A merger would enable elimination of unnecessary duplication to capture large cost savings and realign resources to improve access and quality. The evidence shows there are two additional pressures which drive the necessity for consolidation and reduction in avoidable and unnecessary duplicative cost in order to sustain quality and access. Population stagnation in the region combined with downward pressure on inpatient use rates and downward pressure on government and commercial growth in reimbursement rates create limiting factors even as costs for labor and supplies continue to grow.

In fact, there is a triad of pressures including population trends, use rates and reimbursement. The key areas served by the combined system have seen, and will see, little to no population growth. For instance, Sullivan County and Washington County increased by less than 1 percent, Carter decreased by 1.6 percent, Johnson decreased by 2.3 percent, Unicoi decreased by 2.5 percent, and Hancock decreased by 3.6 percent.² The Virginia counties have seen even worse declines, with Smyth decreasing by 2.3 percent, Russell decreasing by 3.5 percent, and Wise and Scott counties decreasing by 4.2 and 4.5 percent respectively.³

Combining the stagnant population with expected decreasing hospital inpatient use rates will have a serious adverse effect on the health systems. If the Parties remain separate, this will create a shift in the cost structure to a higher percentage of costs being deployed for fixed corporate, rather than clinical, purposes, since each system would be required to sustain duplicative corporate functions and the fixed cost associated with these functions. Consolidation

² *Id.*

³ *Id.*

of the two systems enables a substantial reduction in fixed overhead cost. For instance, the current inpatient use rates in the region, which are 126 per 1,000 population, are higher than the current national range of 106 per 1,000. Given the increasing strategy by payers of shifting to risk-based contracting for physicians, the stated desire of payers to reduce inpatient utilization and the shift to increased use of outpatient services, it is expected that the region's inpatient use rates will decline. Assuming a 2015 population for the 21-county Geographic Service Area of 960,019,⁴ if the current use rates decline to the top of the national range, this would represent a decline of somewhere between 15,000 and 16,000 discharges.⁵ If use rates decline to the lower end of the range, the decline would be as many as 34,000 discharges.⁶

Declines of this magnitude can be offset by population growth, which has occurred in certain areas in the country. In those instances, declining use rates may not mean significant volume declines in hospitals. But in a rural area, where many hospitals are operating at lower volume, it is difficult for hospitals to sustain their efforts with such significant declines in volume. Low population growth and declining use rates are intrinsic to the outlook for this region and there will be a high correlation between declining use rates and actual volume decline in the region's hospitals collectively. Already, many of these hospitals have negative operating margins. Without the COPA, it is likely some of these hospitals will fail. Declining volume in the larger hospitals, combined with the duplicative costs each system will continue to bear, will decrease the ability of those hospitals to financially support the smaller hospitals. It is important to note that if some of these hospitals were to fail, it could potentially lead to reduced access for consumers, and even reduced choice if a hospital were to close. Through the Parties' commitment to utilize synergies to sustain these access points, the COPA provides a rational approach to managing service provision and capacity and the alignment of the combined system based on the needs of the communities.

In addition to these challenges, fixed rate increases in Medicare, commercial plans and Medicare Advantage plans are simply no longer reliable. For the coming federal fiscal year, the region faces yet another decrease in the Area Wage Index. This decrease is despite the fact that the region has the second lowest wage index in the United States. This represents a decrease in federal reimbursement, which cascades to most of the commercial payers.

What is potentially left are two independent systems with significant duplication of fixed administrative cost structures, lower inpatient volumes, and significant clinical duplication dedicated to supporting capacity that may no longer be needed. All of this is combined with a revenue stream which does not support growth in capital investment or even sustainability of the current cost structures.

The Parties believe quality will suffer in this status quo environment as the systems lose their capacity to capitalize or face substantially higher costs for doing so. Remaining separate, the two systems will not have the ability to standardize, eliminate variation and take advantage of scale. These limitations on capital will lead to decreased efforts to diversify the specialties which may

⁴ The population estimate is for the 21-county service area. Sg2 Market Demographics: Population Trends (2016).

⁵ This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 110/1,000.

⁶ This estimate assumes a decrease in inpatient utilization in the 21-county service area from the current rate of 126/1,000 to 90/1,000.

be needed, but do not generate significant revenue, such as pediatrics, and other medical specialties which, ironically, help reduce the demand for inpatient utilization when they are available in the market.

Numerous studies have shown that critical mass in volume leads to better outcomes.⁷ Reduced fragmentation, clinical scale and elimination of variation all become important factors in reducing cost and improving quality. A combined system that is able to utilize the tools and protocols described in the Application is better positioned to use this scale to achieve these desired outcomes than two separate systems would be able to do in a declining admission, population stagnant environment. As outlined elsewhere in this document, another option is for each system to join larger out-of-market systems. Such a system does not have the ability to realign in-area capacity and resources to the benefit of the local economies and community and to improve efficiency and sustainability of care to serve substantial local population health needs of Medicare, Medicaid, uninsured, and commercial patients in largely rural communities.

Assessment: In addition to maintaining the scale needed as a counter to population stagnation and decreasing usage rates, to achieve enhanced quality of hospital and hospital-related services, the New Health System should adopt, implement and fund technology, policies, and programs that are not possible for the two separate and competing health systems to accomplish. This should include the following essential components:

- **Common Clinical IT Platform:** A Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care and will also facilitate the development and increased adoption of best practices and evidence-based medicine implemented by the New Health System. Availability of immediate system-wide alerts and “hard-coding” best practice protocols for clinical pathways has been demonstrated to enhance overall quality by reducing the risk of clinical variation and lowering the cost of care by decreasing duplication of health care services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for the New Health System. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. While some might argue that the two systems, remaining independent, could collaborate on these issues, the Parties strongly disagree. Even if Mountain States were to acquire the EPIC system independently, the IT systems would not be identical, and patients would continue to have two records – one for Wellmont and one for Mountain States. Protocols between the two systems would not be identical and the accountability structure (i.e., the Boards of Directors) would remain separate. There would be little incentive for physicians, who remain competitive, to share information. The collection of data for academic studies and research purposes would be

⁷ See *High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, *Journal of Trauma and Acute Care Surgery*, January 2013, available at: <http://www.ncbi.nlm.nih.gov/pubmed/23271089>. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, *Journal of American Medical Association*, March 2001, available at: <http://jama.jamanetwork.com/article.aspx?articleid=193615>.

further complicated by the need to navigate two separate systems with separate protocols and data sharing capabilities.

- Region-Wide Health Information Exchange - A region-wide health information exchange that includes the New Health System, independent providers, medical groups and facilities in an effective collaborative model will encourage and support patient and provider connectivity to the New Health System's integrated information system. Though a health information exchange does not have the ability to achieve the level of clinical integration possible through a common electronic medical record system, it is an important component for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, the New Health System will commit financial resources to the utilization of an effective health information exchange. These incremental resources will contribute to the sustainability of an effective health information exchange model.
- System-Wide Clinical Council - System-level clinical councils have the ability to drive clinical effectiveness, manage change, and evaluate initiatives through physician leadership and expertise. Best practice and local feedback demonstrates that the New Health System should establish a Clinical Council composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates—including those physicians that practice in hospitals as well as those that practice primarily in outpatient environments. Further, the Clinical Council should be supported by other clinicians, subject matter experts, and senior management. This group should report frequently to the board of the New Health System through the Chief Medical Officer to facilitate the board's responsibility for quality improvement. Nationally, clinical councils are effective in establishing common standards of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices. For the New Health System, the Clinical Council should also provide input on issues related to clinical integration and support the goals established by the Board of Directors of the New Health System.
- Quality Reporting - Effective quality reporting is an essential component of any integrated clinical system with accountability to the community. This calls for complete transparency on quality measures with respect to the performance of the New Health System on a common and comprehensive set of measures readily available for consumers. This will impact choice and further incentivize the provision of high-quality care. Increased transparency will provide consumers with information to make better health care decisions. For meaningful comparison, this reporting system should include CMS core measures including patient experience scores for each facility within thirty days of reporting the data to CMS. The reporting system should also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available and as far in advance of the federal agency reporting as possible.

The Parties believe quality will not diminish under the COPA and point to the experience of Mission Health in Asheville as support for this position. Mission Health was granted a COPA in

1995 and has been recognized nationally for its low cost and high quality health care. For seven years in a row, Mission has been named a Top 100 hospital, and for three years in a row, has been named a top 15 health system in the nation. Under the COPA, quality at Mission has been sustained and costs are lower relative to their peers. According to data provided by the State of North Carolina, the costs for health care services at Mission have been sustained at a lower level than its peers in the state. In fact, Mission Health has been recognized as one of the best examples in the country of health systems that have successfully achieved higher quality while maintaining low costs.⁸

Competition was reduced in Asheville by the merger, but, because of the implementation of the COPA and state supervision over Mission's commitments, health care costs have remained low and health care quality has improved. The Parties note that the U.S. Department of Justice and the North Carolina Attorney General's Office recently took legal action against another health system in North Carolina (Carolinas HealthCare). The legal action alleges anticompetitive behavior by Carolinas Healthcare which could increase pricing and reduce consumer choice.⁹ The claims made against Carolinas Healthcare have never been made by a federal or state agency against Mission Health. The Parties note that the anticompetitive behaviors that Carolinas Healthcare has allegedly engaged in are explicitly prohibited by the COPA regulating Mission Health, and Mission has not engaged in such behaviors. The Parties have proposed commitments in their Application that are similar to the Mission Health commitments. These are intended to prohibit the anticompetitive behaviors that triggered the federal and state action against Carolinas Healthcare. The Parties believe such commitments, when properly supervised, reduce the likelihood of the behavior alleged by the Department of Justice in the Carolinas Healthcare case, and protect high quality and low cost.

Recommendation: To ensure that enhanced quality of hospital and hospital-related care is provided to Tennessee citizens under the merger, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
- The New Health System will participate meaningfully in the exchange of health information open to community providers.
- The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.
- The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully in the Application.

⁸ See "Mission One of Ten Hospitals Named for 'Doing It Right,'" *Mission Health Scope*, August 7, 2009, available at: http://www.mission-health.org/sites/default/files/document-library/1292_0.pdf (accessed July 12, 2016).

⁹ See "State and feds say Carolinas HealthCare drove up costs by curbing competition," *The Charlotte Observer*, June 9, 2016, available at: <http://www.charlotteobserver.com/news/local/article82726402.html> (accessed July 12, 2016).

- The New Health System will collaborate with independent physician groups to develop a local, region-wide clinical services network to share data, best practices, and efforts to improve outcomes for patients and the overall health of the region.

(B) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities;

Situation: The Parties believe that it will be increasingly difficult to continue financially supporting rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services is a driving impetus for the Cooperative Agreement. The COPA is the only means to achieve the efficiencies necessary to sustain rural facility operations and preserve and enhance access to quality care in geographical proximity to the communities traditionally served by those facilities.

Background: Health care services offered by rural hospitals in the United States are increasingly at risk of closure. According to the University of North Carolina Sheps Center, seventy-six rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia.¹⁰

Providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, and higher patient out-of-pocket costs due to increased copayments and deductibles which have led to more hospital bad debt. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.¹¹

As presented in Tables 5.2 and 5.3 of the COPA Application, many of the Parties' rural hospitals have an average daily census of twenty patients or less. Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals.

Last year alone, Mountain States and Wellmont collectively invested more than \$19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital, Dickenson Community Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center.

In the current resource-constrained, status-quo environment, these hospitals face an uncertain future with respect to their viability, and, in fact, may be in peril. A recent report estimates 673

¹⁰ See *76 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, available at: <https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/> (accessed July 13, 2016). Ten rural hospitals have closed since the COPA Application was filed in February, 2016, including two rural hospitals in Tennessee.

¹¹ County-level data for the region is available at 2015 "Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available at: <https://www.tn.gov/health/topic/specialreports/>.

rural hospitals are vulnerable or at risk for closure nationwide.¹² The existing threat to these hospitals is substantial, which affects not only patients' access to local care in geographic proximity to their homes, but also affects the economic vitality of these communities.

These rural facilities are supported by three regional tertiary hospitals located along major highways that connect the rural markets to the Tri-Cities. These hospitals—Johnson City Medical Center, Bristol Regional Medical Center, and Holston Valley Medical Center—serve distinct patient bases in a hub and spoke model to distinct rural geographies. Each of these hospitals provides an array of high-level services that are essential to the greater Tri-Cities region of Northeast Tennessee and Southwest Virginia communities they serve. They are also major regional teaching facilities with a variety of academic partners in Virginia and Tennessee. The financial support for these rural hospitals is generated largely by the tertiary facilities. As stated earlier in this document, population stagnation and decreased inpatient use rates will increasingly challenge these hospitals' ability to continue supporting rural facilities as redundant, duplicative costs remain.

Assessment: The COPA is a mechanism for ensuring that the efficiencies from the merger will be used to ensure sustained access to care for these communities. *Without the Cooperative Agreement and the commitments in the COPA, there is no comparable assurance from the two health systems.* The Parties believe the evidence supports the assertion that these hospitals are threatened as population stagnates and financial support from the tertiary facilities become increasingly difficult to sustain. The commitment to keep these facilities open and to preserve access to existing healthcare services in these rural markets creates a public advantage that does not exist today and that cannot exist without the merger. This commitment also mitigates the risk that healthcare services will not be maintained in reasonable geographical proximity to the communities served by these hospitals. The timeframe associated with this commitment should acknowledge that healthcare services are constantly evolving locally and nationally and some repurposing of existing facilities may be needed to meet specific community needs, some of which are not necessarily being met today. The commitment should also address retention of high-level tertiary services in a teaching hospital environment at the region's existing tertiary hospitals.

Recommendation: In order to preserve hospital facilities in geographical proximity to the communities traditionally served by those facilities, Mountain States and Wellmont have proposed the following commitments to be actively supervised by the state:

- All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

¹² See 2016 Rural Relevance: Vulnerability to Value. A Hospital Strength INDEX Study. Ivantage. Accessed on June 13 at <https://tinyurl.com/j3gaatc>.

- The New Health System will maintain the three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.

(C) Gains in the cost-efficiency of services provided by the hospitals involved;

Situation: The existing competitive dynamic between Wellmont and Mountain States has led to expensive duplication of equipment and facilities. The merger would allow the New Health System to achieve greater cost efficiencies through various organizational and administrative efficiencies, including non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform.

Background: Federal and state regulatory agencies impose significant cost constraints on all hospital providers. Medicare and Medicaid payment rates are non-negotiable and are often applied as benchmarks by other payers. Medicare costs are regulated through the Medicare Wage Index. In Northeast Tennessee and Southwest Virginia, payment rates remain lower because the local Medicare Wage Index is one of the lowest in the nation. With a payer mix for the regional health systems that is approximately 70% Medicare, Medicaid, and Medicare managed care, this wage index serves as a fundamental regulator of health care costs.¹³

Assessment: The proposed Cooperative Agreement complements federal and state efforts to contain costs and promote cost efficiency in several ways.

Through the Cooperative Agreement and the commitments in the COPA, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region with low population density. No other region in Tennessee operates two Level I Trauma Centers.

Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher-volume trauma centers result in better patient outcomes.¹⁴ Thus, a consolidation is not only likely to result in lower cost, but it is also likely to result in improved outcomes. Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities. This repurposing will lead to higher volumes in the acute care and other consolidated facilities, and thus, better efficiency. The quality of care is also expected to improve since studies indicate quality is generally better in higher volume environments.¹⁵

¹³ See Application Exhibit 5.1C for a breakdown of payers in the Geographic Service Area.

¹⁴ See *High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, *Journal of Trauma and Acute Care Surgery*, January 2013, available at: <http://www.ncbi.nlm.nih.gov/pubmed/23271089>. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, *Journal of American Medical Association*, March 2001, available at: <http://jama.jamanetwork.com/article.aspx?articleid=193615>.

¹⁵ *Id.*

Access is also expected to improve because the repurposed facilities may be able to add services that could not be previously supported in an environment of duplication and low capacity.

Recommendation: To ensure the merger results in gains in the cost-efficiency of services provided by the hospitals involved, Wellmont and Mountain States have committed to achieve at least \$95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities.

(D) Improvements in the utilization of hospital resources and equipment;

Situation: Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers.

Background: Collectively, Wellmont and Mountain States serve a region with one of the highest inpatient use rates. Currently, for every 1,000 people in the region, 126 are admitted to the hospital annually, compared to a national average of 106 admissions per 1,000. The current lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region which contributes to the overutilization of costly inpatient services. Unnecessary duplication of high cost services contributes to this trend. A major factor in the accumulation of nearly \$1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. These costs must be covered through clinical revenues and that contributes to higher costs.

Moreover, providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, higher patient out-of-pocket costs due to increased copayments and deductibles (resulting in additional declining revenue to the hospitals as the deductibles are increasingly uncollectable by hospitals), and a variety of other pressures stemming from an understandable frustration with the cost of health care. The challenges are intensified in the Parties' service area of Northeast Tennessee and Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges. In the coming years, inpatient utilization rates are projected to decline, while fixed infrastructure costs remain.

Assessment: Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost and enable the New Health System to reduce overutilization of inpatient services and stem the pace of healthcare cost growth for patients, employers and insurers. These efforts will enable the creation of a regionally integrated health system, with a comprehensive regional health information exchange, that will help reduce unnecessary utilization. This integrated delivery model will not

be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

Because of their regional proximity and high levels of duplication, the Cooperative Agreement will enable the two health systems to avoid unnecessary duplication and over-utilization thereby containing costs, achieving greater efficiency and improving utilization of high-cost hospital services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes.

One example of how the integrated delivery system could reduce the utilization of hospital resources is behavioral health. According to the American Hospital Association, one in four Americans experiences a behavioral health issue or substance abuse disorder each year, with the majority of those also experiencing physical health conditions or chronic diseases that complicate care needs. Thus, these patients typically have higher levels of health care utilization. It has been estimated that medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have a mental health/substance abuse disorder. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse that reduces unnecessary hospital utilization.

These efforts could not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information, the fact that reduction in duplication of resources would absolutely not occur without the merger and the significant commitment of resources to be made by the Parties. Specifically, the Parties have committed to investing millions of dollars in new behavioral health community-based services, residential addiction recovery services, and a Common Clinical IT Platform that are needed to create an integrated system and would not be possible without the merger. Moreover, commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems.

In order to most efficiently utilize hospital resources, important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care to appropriately address the utilization of hospital resources. In fact, effective systems of care and provider resources in the outpatient environment and the community go a long way in reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the development of outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services will help manage the utilization of hospital resources.

Recommendation: To ensure the merger results in improvement in the utilization of hospital resources and equipment, the New Health System has proposed certain commitments which can only be funded through the cost-containment, cost-efficiency, improved utilization, and avoidance of unnecessary duplication derived from the merger. These commitments include the

adoption of a Common Clinical IT Platform for electronic medical records among the combined nineteen hospitals, employed physicians and related services and facilitation of a community health information exchange between participating community providers in the region. This combination will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patients' access to their own health information. A more fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services resulting in a better patient experience and more effective and efficient care.

The New Health System has also proposed creation of a local clinical network which would partner the health system with the physician community in sharing data, best practices, standardization of care models and reduction of unnecessary utilization.

(E) Avoidance of duplication of hospital resources;

Situation: A major factor in the accumulation of nearly \$1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate health care systems. The significant ongoing duplication of health care services and costs in the region cannot be avoided without a consolidation. Funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost-savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services.

Background: Wellmont and Mountain States have competed with each other in certain areas and with other health care providers since the formation of the two systems in the late 1990s. A result has been the unnecessary duplication of hospital resources that has not added value. By eliminating the duplication of hospital resources and investing in what evidence has shown will help make this region healthier, the Parties believe the New Health System will be able to control costs and make healthcare more affordable.

Assessment: Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will provide savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources.

The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to identify the unnecessary duplication of hospital

resources and perform an economies and efficiencies analysis regarding the proposed savings and efficiencies that would be gained by the merger. As detailed on pages 82-84 of the Application, the economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies").

The Parties have identified potential savings from the merger in the following areas that would not be possible but for the merger:

- Non-Labor Efficiencies
 - How the Merger Would Help: Cost-savings can be achieved through operational efficiencies. Examples include combined purchasing and use of a non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals.
 - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in non-labor expenses totaling approximately \$70 million annually.
- Labor Efficiencies
 - How the Merger Would Help: The New Health System will reduce workforce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system.
 - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in labor expenses totaling approximately \$25 million annually.
- Clinical Efficiencies
 - How the Merger Would Help: The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations.
 - Estimated Savings from the Avoidance of Duplication: The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually.

Further, the extensive commitments described in the Application to improve access to health care and quality of health care could not be achieved without the combination and would not be effectively enforced absent an active state supervision program mandated by Virginia and Tennessee law.

Recommendation: To ensure the merger results in the avoidance of duplication of hospital resources, the New Health System has proposed certain commitments that would eliminate the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. Specifically, Wellmont and Mountain States have committed to achieve at least \$95 million in annual efficiencies by the end of the fifth year of operation. The potential savings are limited to

the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities. By eliminating duplications, and the costs associated with those duplications, the New Health System will be able to re-direct those resources to maintaining and improving quality rather than duplicating services that result in excess capacity or underutilization. These efforts will provide resources that can be invested in more value-based spending in the region – spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

(F) Demonstration of population health improvement of the region served according to criteria set forth in the agreement and approved by the department;

RESPONSE: The population served by Mountain States and Wellmont has long had more significant health challenges than the population in the United States generally. The area served by the Parties has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.¹⁶ Behavioral issues prevalent in the community, such as drug use, smoking, and poor nutrition, have made these conditions particularly difficult for health care providers to address in a meaningful way.

The New Health System commits to implementing programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome in the Geographic Service Area, as outlined in the template Community Health Improvement Plan, attached as Exhibit 21 to these Responses. Suggested short-term and intermediate-term outcome metrics are included in the template Community Health Improvement Plan. Because of limitations and lags in current federal and state population health data sources, especially at the county level, the Parties expect that final metrics and targets will be agreed upon with the Tennessee Department of Health. In order to make data actionable, new or augmented data collection efforts may be necessary. The "Year-by-Year Summary" that provides an estimate of the year-by-year timing of these reinvestments and cost savings is attached as Exhibit 22. All of these efforts recognize that ultimately, individual and community health and well-being are not primarily driven by health care services, but instead by income, education, family and community support, personal choices, genetics and the environment.

The New Health System expects to work collaboratively with the State to determine which specific interventions will be implemented where. While many evidence based programs exist to reduce tobacco use, obesity, drug poisoning, etc., it may not be possible to implement these locally without modification due to workforce, transportation or other infrastructure constraints.

¹⁶ County-level data for the region is available at 2015 "Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available at: <https://www.tn.gov/health/topic/specialreports/>.

Combining two strong health systems aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to direct resources in a coordinated way and tackle these longstanding, expensive problems that reduce quality of life for so many of the state's most vulnerable citizens and communities.

(G) The extent to which medically underserved populations have access to and are projected to utilize the proposed services; and

Situation: Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. Wellmont and Mountain States anticipate significantly improved access to health care services under the Cooperative Agreement and the commitments set forth in the COPA. The Cooperative Agreement will enable the hospitals to improve access to medically underserved populations through charitable care programs as well as continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The COPA will ensure that the New Health System is held accountable for the commitments the Parties have made to the state.

A recent *60 Minutes* story highlighted Wise County, Virginia as an example of gaps in access to care for non-hospital services and misplaced resources.¹⁷ Wise County has a population of 47,000 people that is steadily declining - yet there are three full service hospitals in the county, each with a census below 30. The reporter told the story of uninsured patients with chronic health conditions who aren't able to access the primary care services they need. Resources that could be spent on lower cost primary care and disease management initiatives are tied up in three acute care hospitals. How does this happen? Unfortunately, the incentives are improperly aligned. Today, hospitals in Wise County, and many other rural areas, are incentivized to provide acute care services, invest in physicians who perform high-cost procedures, and expand services for competitive reasons, even if they are duplicative. Yet, the fundamental health care needs of the population are not being met. The resources are there, but there is no organized incentive to change the model to address the needs of the region. The COPA creates this incentive. By eliminating irrational competition, the New Health System will be able to reduce unnecessary cost, and refocus its resources to provide access for the medically underserved. Shifting physical resources and personnel to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

Background: Populations are medically underserved in this region for lack of insurance and lack of providers. Wellmont and Mountain States currently provide significant amounts of charity care to uninsured and underinsured populations in the Geographic Service Area¹⁸ and will continue to do so in the future in accordance with IRS guidelines for not-for-profit hospitals. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Parties currently provide. The new policy will provide a 100%

¹⁷ See *On the road with the Health Wagon*, 60 Minutes, March 24, 2016, available at: <http://www.cbsnews.com/videos/on-the-road-with-the-health-wagon> (accessed July 10, 2016).

¹⁸ In fiscal year 2015, Wellmont provided \$72,940,011 in uncompensated care. See Wellmont's IRS Form 990 for fiscal year 2015.

discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential. For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments. The Parties believe this is a significant advantage that will offset any potential disadvantage that results from the reduction in competition. Reduced pricing and improved quality and access to services are key to this particular commitment.

Both systems also subsidize physicians, services and facilities in areas that lack medical care. But there are still considerable unmet needs. As neither Tennessee nor Virginia is a Medicaid expansion state, the number of uninsured will persist and as high deductible health plans grow, the number of effectively under-insured will continue to rise beyond current levels.

As far as services, mental health, substance abuse and specialty pediatric services are three areas the Parties have identified as priority for investment. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Assessment: To address the uninsured populations that need access to affordable health care, will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.

As detailed in the Application, the New Health System intends to partner with, or support, existing community based charity clinics along with rural health clinics and Federally Qualified Health Centers ("FQHCs") to help people access the care they need rather than creating new charity clinics. There are many effective charity care clinics and programs already operating in the region, and the New Health System believes that partnering with or supporting these established programs will be the best use of community resources. An established network of care options will be especially important as the New Health System seeks to enroll indigent or uninsured high-use, high need individuals in the "super-utilizer" accountability model mentioned in Response #7. Under this program and the regional network of primary care providers, the New Health System will encourage individuals to participate more actively in their health and to employ prevention and disease management strategies so that high cost health care utilization can be avoided. Effective management of the health of this population in partnership with charity care clinics and FQHCs along with social agencies and others will reduce the cost of health care in the region overall and allow the New Health System to keep costs lower for everyone. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

The uninsured population will also be the target of several inter-related health strategies outlined in the Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area – Wellmont currently holds an active federal grant for these navigator services, Mountain States does not.

In addition, the proposed partnership is committed to efforts to improve overall health services to the medically underserved areas. In cooperation with the College of Public Health at East Tennessee State University ("ETSU"), the Parties launched the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups were created to specifically focus on medical needs of the medically underserved,

identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. The Parties jointly sponsored and funded these four Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement.

The Community Health Work Groups met during the Fall of 2015 in public meetings throughout Northeast Tennessee and Southwest Virginia to seek community input. The meetings were led by subject matter experts and included business and community leaders from throughout the region who represent a broad variety of experience and perspectives. The meetings were also staffed by members of Mountain States and Wellmont along with master's and doctoral-level students from ETSU. ETSU was engaged jointly by the Parties to analyze the community input received at these Community Health Work Group meetings and to develop a 10-year plan for addressing these community health opportunities for improvement.

As key access points increase, the Parties expect additional utilization from medically underserved populations to increase also. Additionally, as the New Health System's charity care policy becomes more generous and more widely known, the New Health System will be able to engage with the uninsured population in a way that proactively connects people to services – including primary care, health management services, and social needs navigation functions. While utilization is expected to increase overall, the Parties do expect there to be a shift, however, from higher cost inpatient and emergency department use to lower cost outpatient use and utilization of health management services.

Recommendation: The Cooperative Agreement will allow the hospitals to redirect efficiencies to continue to support programs and services that do not currently exist or are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. To ensure the merger results in improved access to health care for the medically underserved under the Cooperative Agreement, Wellmont and Mountain States have proposed the following commitments to be included in the COPA and actively supervised by the state:

- The New Health System commits to spending at least \$140 million over ten years pursuing specialty services as detailed below which otherwise would not be sustainable in the region without the financial support of the transaction.
- The New Health System commits to creating new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- The New Health System commits to ensuring recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- The New Health System commits to development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.
- The New Health System commits to development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.

- Implementation of an organized care delivery model for the uninsured which would provide significantly higher pricing discounts to individuals who agree to participate meaningfully in an organized accountability model which guarantees access and lower pricing in return for improved individual health behaviors among the uninsured population.

(H) Any other benefits that may be identified.

Situation: In addition to the benefits identified above, Wellmont and Mountain States expect the Cooperative Agreement to result in additional benefits for the region. These benefits will include: increased behavioral health and substance abuse services, enhanced health IT capabilities, robust academic and research partnerships, and a commitment to workforce development. The Parties will be held accountable for their commitments through the COPA.

Background: Both systems are committed to maintaining the viability and vitality of regional assets in order to ensure access, manage the future costs of healthcare for local employers, and address the serious health issues affecting the Geographic Service Area. Given the multitude of challenges faced by the two systems, combined with the consolidation that is occurring throughout the industry among hospitals, physician groups, insurance companies and even health information technology companies, it is clear that neither Wellmont nor Mountain States will be able to remain independent moving forward. Given this reality, two options exist: merge locally to capture large merger-specific efficiencies and quality-enhancement opportunities through an integrated, locally governed regional health system or independently merge with large healthcare systems, located and controlled from outside the region – a step that would not come close to achieving the merger-specific benefits of a Wellmont-Mountain States integration. The proposed transaction, by far, positions the region to achieve the greatest level of public advantage and cost containment.

Assessment: In addition to the other benefits listed above, Wellmont and Mountain States expect the Cooperative Agreement to result in the following benefits for the Geographic Service Area:

- Behavioral Health and Substance Abuse Services. Behavioral health and substance abuse issues are a major health factor in the geographic area served by the Parties, and there are currently significant gaps in the continuum of care related to these issues. As part of the public benefit associated with the merger, and the \$140 million commitment, the New Health System is prepared to make major investments in programs and partnerships that will help to address these issues. The societal cost associated with mental illness and substance abuse is extensive, and, given that the single largest diagnosis related to regional inpatient admissions is psychoses, these issues merit priority attention. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to support the development of effective behavioral health and substance abuse resources to provide high-quality, well-coordinated, and more proactive care.

The Parties recognize that important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care. In fact, effective systems of care and provider resources in the outpatient environment and the community will contribute to reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the main focus of development in this area will be outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services. The New Health System will work within the existing framework of resources and partnerships across the region to identify needs associated with this area as well as gaps in service offerings. The Parties expect to identify a more integrated care model similar to what is outlined by the Agency for Healthcare Research and Quality ("AHRQ") for the region through the efforts of the Community Health Work Groups. That model includes primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care addressing mental health, substance abuse conditions, health behaviors, life stressors and crisis, stress-related physical symptoms, and ineffective patterns of health care utilization. The work of AHRQ and other evidence-based best practices will be used as a guide to support the development of regional services in a model that is coordinated, co-located, and integrated to overcome the disparate and disconnected manner in which individuals are currently treated. The New Health System will support a network of care resources across the region in partnership with agencies such as Frontier Health, Highlands Community Services, the regional rural health centers and Federally Qualified Health Centers, faith-based organizations, and health departments. Together with these partnership networks, the care resources associated with the New Health System, including primary care networks, emergency department networks, and inpatient behavioral health, will position the system to positively impact the development of this continuum of resources in an unprecedented way.

- Enhanced Health IT Capabilities. The Cooperative Agreement will allow the New Health System to leverage its integrated technology systems, combined with data from within the community to better coordinate population health efforts. By creating a "single team" approach, the combined system will promote collaboration across inpatient and outpatient care environments, engage patients, and manage health care data to promote healthier living and manage chronic care conditions.
- Academic and Research Partnerships. A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical system which can help transform health care delivery and address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of research and academic enhancement to bring specific health care and economic benefits to the community. The Parties intend for the academic health system to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty,

expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors, thereby benefiting the communities with overall health and economic wellbeing.

- Workforce Development. In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by being competitive with neighboring health systems. The Parties believe that by carrying through on the commitments in the Application, the New Health System will become a nationally recognized model which will attract highly talented team members and physicians who want to be part of a health care solution not necessarily offered elsewhere.

Recommendation: Wellmont and Mountain States anticipate significant benefits from the merger, including increased behavioral health and substance abuse services, enhanced health IT capabilities, improvement in the quality and availability of health care services, robust academic and research partnerships, and a commitment to workforce development. To ensure these benefits outweigh any potential disadvantages associated with the transaction, Mountain States and Wellmont make the following commitments:

- Behavioral Health and Substance Abuse Services
 - As part of its \$140 million commitment, the New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region. This service is not broadly available without sufficient capacity, and there are no plans by any entity to develop and build an integrated residential treatment facility. This benefit would not occur but for the transaction.
 - The New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.
- Enhanced Health IT Capabilities
 - The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
 - The New Health System will commit to participate meaningfully in a health information exchange open to community providers.
- Academic and Research Partnerships
 - The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.
 - With its academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, physician assistants, and other allied health professionals in the region.
 - The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan

for investment in research and growth in the research enterprise within the region.

- Workforce Development
 - The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.
 - The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.
 - The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

Potential Disadvantages of the Proposed Merger

The department's evaluation of any disadvantages attributable to any reduction in competition likely to result from the agreement shall include, but need not be limited to, the following factors:

(A) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed healthcare organizations, or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals, or other healthcare providers;

Background: Depending on the facts, mergers can “enable the merged firm to reduce its costs and become more efficient, which, in turn, may lead to lower prices, higher quality products [or services], or investments in innovation.”¹⁹ Tennessee’s COPA law recognizes these principles as they apply to healthcare mergers through the list of potential advantages identified in the statute. Also under certain facts, mergers can result in market power, which can be exercised by raising price, reducing quality or slowing innovation.²⁰ The COPA law’s list of potential disadvantages reflects this principle as well.

Assessment: While anticompetitive effects may be a disadvantage resulting from some unregulated mergers, even if such effects were otherwise likely here, the Legislature, through the COPA, as implemented under the Rules, provides the Department with an effective means to address this potential disadvantage by actively supervising the payer contracts entered into by the merged entity.

The major payer mix for the proposed Geographic Service Area of the New Health System (Application Exhibit 5.1-C) is:

Medicare	38.6%
Medicaid	17.0%
Medicare Advantage	14.7%
Commercial	17.5%
Self-Pay	6.2%

Because fee-for-service Medicare and Medicaid payments to hospitals are established by formula and largely unaffected by price competition, the principal category of payers that could potentially be disadvantaged by a merger are commercial health plans and their enrollees (including Medicare and Medicaid managed care). These payers also represent a substantial share of total enrollment in the Tennessee and Virginia service area, respectively. As such, it is important for the Parties to be included in contracts with each of these payers.

The combined inpatient share in the proposed Geographic Service Area for the New Health System is approximately 73 percent. The combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on

¹⁹ Commentary on the Horizontal Merger Guidelines, Federal Trade Commission and U.S. Department of Justice (2006) at 1, available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/commentaryonthehorizontalmergerguidelinesmarch2006.pdf>.

²⁰ Id.

the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E).

The Parties recognize that absent the active supervision of a COPA, there is a concern that the New Health System could potentially be able to obtain increased prices from non-governmental payers for whom prices are subject to negotiation. The Parties believe that the current and future market conditions in which the New Health System operates impose both substantial constraints on their pricing and quality and incentives to achieve improved outcomes. Among these are the relatively small proportion of patients covered by commercial contracts relative to Medicare, Medicaid, and other non-commercial or uninsured business, and the substantial share of enrollment held by the New Health System's largest two payers. The New Health System will have every incentive to negotiate with these payers in order to be able to attract patients and avoid loss of patients to other hospitals. In addition, as noted elsewhere, the Parties have committed to invest significantly in the communities in which they operate in the form of new services, enhanced services and locations, programs and initiatives to improve population health, and targeted investments on the highest priority health issues. These provide the incentive to achieve efficiencies and to improve health and outcomes, so as to sustain investments.

Nonetheless, there are certain mechanisms that the Parties have proposed that could be adopted by the State to actively supervise the payer contracts entered into by the merged entity to address this potential disadvantage.

Recommendation: In order to prevent the New Health System's ability to exercise any increased market or bargaining power achieved through the merger that could adversely impact the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will negotiate in good faith with Principal Payers²¹ to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System would agree to resolve through mediation any disputes in health plan contracting.*

How this commitment would prevent the potential disadvantage: This commitment by the New Health System would prevent the New Health System from rejecting in-network participation for payers constituting more than two percent of the New Health System's revenue if terms and rates offered were commercially reasonable (a judgment itself subject to the State's active supervision). Because the New Health System would be required to negotiate in good faith with all Principal Payers who offer commercially reasonable terms, or risk violation of the terms of the COPA, the New Health System

²¹ For purposes of the Application and this Response, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

would have no leverage to demand anticompetitive rates. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA. In addition, any disputes in health plan contracting between the New Health System and the Principal Payers would be subject to mediation. Mediation consists of confidential negotiations facilitated by a third-party neutral whose role is limited to helping parties arrive at a mutually agreeable resolution to the dispute. Mediation is less expensive than litigation and less time-consuming. The Parties believe the commitment to mediation will help expeditiously resolve any disputes that arise with Principal Payers in order to minimize the impact a dispute may have on covered beneficiaries.

2. *The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.*

How this commitment would prevent the potential disadvantage: This commitment would prevent the New Health System from requiring payers to contract with the merged entity exclusively in the proposed Geographic Service Area. The result is that consumers will continue to have network choices beyond the New Health System and providers will have an alternative to contracting solely with the New Health System or its network. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

3. *The New Health System will not engage in "most favored nation" pricing with any health plans.*

How this commitment would prevent the potential disadvantage: A most-favored-nation clause is any term in an agreement between a payer and a provider that stipulates that either a) the provider give the payer the lowest rate that it contracts with any comparable payer or b) the payer must give the provider the highest rate that it contacts with any comparable provider. This commitment will preclude the New Health System from obtaining a promise from a health plan that it will be paid as much as, or more than, any other provider with which the health plan contracts. Such a commitment controls the New Health System's ability to exercise any alleged market or bargaining power achieved through the merger to require payers to pay them the highest price available in the market. Alternatively, where a large payer may require the lowest possible rate contracted in the market from the New Health System, this commitment would prevent a scenario whereby the New Health System is reluctant to offer discounts to other payers. Such activity could prevent other, possibly more competitive, payers from effectively competing in the market. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

The Parties believe that including these commitments in the COPA will prevent the New Health System from exercising any possible market or bargaining power achieved through the merger to adversely impact the ability of health maintenance organizations, preferred provider

organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals or other healthcare providers. The Parties presume that, to ensure the disadvantage is prevented, the State will actively supervise these commitments through annual reporting requirements.

(B) The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the cooperative agreement;

Background: Depending on the facts, consolidation between health system competitors could result in a net benefit for patients, employers and payers by fostering integrative efficiencies, realignment of resources and improved opportunities for value-based care and population health improvement. In a given case, the elimination of competition between merging parties could also facilitate market power to engage in exclusionary practices that foreclose other healthcare providers or suppliers from access to the market and lead to increased prices for consumers.

Assessment: Although the merger will eliminate competition between the Parties, the COPA is the mechanism created by the Legislature to allow beneficial mergers while ensuring through active state supervision that consumers retain those benefits. Through this statutory authority, the State is able to protect its citizens from anticompetitive activity and simultaneously allow the New Health System to address the region's major population health issues and related healthcare challenges.

As noted above, the combined facilities share for outpatient services (Application Exhibit 6.1-A to 6.1-D) ranges between 0 percent and 55.6 percent depending on the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area (Application Exhibit 6.1-E). The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. The Parties acknowledge that for general acute care inpatient services, the merger creates a relatively concentrated proposed Geographic Service Area.

Without active supervision under the authority of the COPA law, it is possible the merger would empower the New Health System through exclusionary practices to foreclose market access by physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. There are, however, certain mechanisms that the Parties have proposed that could be adopted by the State to actively supervise the merger and ensure that consumers reap the expected benefits of higher-quality, more affordable care from the merger.

Recommendation: In order to prevent the New Health System from reducing competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals in a way that results in disadvantages, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors.*

How this commitment would prevent the potential disadvantage: A commitment to maintain an open medical staff at all facilities will ensure equal access to all qualified physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This will ensure that independent physicians who meet the rules and conditions of the organized medical staffs of each facility will not be disadvantaged compared to physicians employed or contracted by the New Health System. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

2. *The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the Board of Directors.*

How this commitment would prevent the potential disadvantage: Independent physician practices frequently depend on the ability to see patients at multiple facilities to provide services or manage populations for whom they've assumed risk. A commitment to abstain from exclusive contracting for certain non-hospital-based physician services will enable independent physician practices to continue to compete with physicians employed or contracted by the New Health System. The New Health System will restrict any exclusive contracting to certain hospital-based physicians, like hospitalists, radiologists, pathologists, or emergency-room physicians, as approved by the Board of Directors. The best practice in the industry for preserving quality and managing cost in these hospital-based departments is for such services to be managed by a single physician group, with such group being held to standards determined by the leadership of the hospital in collaboration with the group. As an example, it would not be optimal for a hospital to have multiple ER physician groups staffing the ER, laboratory or radiology, as doing so would risk confusion and lack of consistency in processes. This is why exclusive contracts for hospital-based physicians are common in hospital markets of any concentration level. For independent physician groups that provide hospitalist services, the New Health System will continue to allow the independent physicians or their hospitalists to follow their patients in multiple hospitals as long as the independent physicians meet the organized medical staff rules and conditions and the metrics related to performance on which the hospital and independent practice agree. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

3. *Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.*

How this commitment would prevent the potential disadvantage: Exclusive contracting has the potential to reduce competition by requiring physicians to render services only at facilities of the New Health System. Restricting the practice of independent physicians

to the New Health System's hospitals and other facilities has the potential to reduce the number of referrals in the proposed Geographic Service Area available to competing providers, and reduce the labor supply of physicians necessary for these providers to operate in the market. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

4. *The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.*

How this commitment would prevent the potential disadvantage: Prohibiting or disincentivizing independent physicians from participating in health plans and provider networks of their choice has the potential to reduce competition and raise prices for insurers contracting to form provider networks. A commitment to not engage in such practices (be they as conditions for obtaining privileges or for other reasons) ensures continued competition among health plans and providers. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the State through annual reports attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

5. *The New Health System will participate meaningfully in a health information exchange open to community providers.*

How this commitment would prevent the potential disadvantage: A health information exchange built off a Common Clinical IT Platform has the potential to improve coordination of care and quality of health care services across the region. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, the New Health System has committed to participating in a health information exchange open to community providers. The New Health System will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians. Additionally, the New Health System will utilize the data for its own employed physicians and service locations where the use of this data will enable improvement in the coordination of care. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance once the health information exchange is fully established and the State would have the ability to enforce this commitment under the COPA.

6. *The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.*

How this commitment would prevent the potential disadvantage: A health system that achieves increased market share or bargaining power through a merger could potentially obtain labor at more favorable terms and wage rates than in an otherwise competitive market for the purchase of labor. Such an outcome is not likely for the New Health System due to at least two factors, in addition to this commitment: 1) the low

area wage index that the region is currently assigned by the federal government creates competition for labor from outside the Geographic Service Area, and the merger will not reduce this competition 2) the New Health System will not have a dominant share in the outpatient and physician services market which are attractive alternative employment options for hospital staff.

To further ensure that employees are not disadvantaged by the loss of competition between the Parties, the New Health System will commit to honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave. This commitment would be actively supervised by requiring the New Health System to file a report to the State attesting to compliance after the first year after formation of the New Health System and the State would have the ability to enforce this commitment under the COPA.

The Parties believe that including these commitments in the COPA will prevent the New Health System, were it to obtain market power through the merger, from exercising it to reduce competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. To ensure the disadvantage is prevented, the Parties propose that the State actively supervise these commitments through annual reporting requirements.

(C) The extent of any likely adverse impact on patients in the quality, availability, and price of healthcare services; and

Background: Depending on the facts, consolidation in healthcare markets can lead to substantial cost savings by eliminating costly duplication of services and equipment and improving quality of care. These benefits can manifest from an increase in the volume of services and ability to provide expanded and coordinated health care services throughout the region. Facts in a particular case can also show that such benefits are unlikely or insufficient to offset anticompetitive effects resulting from the elimination of competition between the parties. If population stagnation continues for the next five years, as current population trends indicate, the reduced inpatient use rates and the downward pressure on reimbursement combined with the financial realities rural hospitals in both systems are facing, it is more likely that not consolidating will have an more adverse effect on both quality and access in those markets and be an outcome far inferior to the merger governed by a COPA. As stated in this Response, the Parties' rural hospitals are in peril, and the evidence shows that rural hospitals in general are at risk, especially in markets with declining population. As use rates decline for the larger tertiary hospitals - hospitals that also operate in markets experiencing population stagnation - it is increasingly unlikely that financial support for these rural hospitals can continue at the current rate. This will lead to reduced capitalization in those markets, and quality and access are likely to suffer. Conversely, as demonstrated within the multiple commitments being made within the Application, it is more likely that quality, availability and reduced pricing will only result from the approval of the COPA. Reduced pricing will occur for the uninsured through additional discounts on pricing in return for participation in organized care managed models of guaranteed access. Importantly, pricing will actually increase more for the insured population if the COPA is not granted, given the commitment to reduce pricing growth already agreed to by payers, and subsequent limits on pricing growth thereafter.

Assessment: The merger will result in the consolidation of some services between the Parties, but not in any adverse impact on the quality, availability or price of healthcare services. The merger creates the opportunity to achieve significant cost-savings and other benefits for consumers. Active supervision through the COPA can preserve, and hold the New Health System accountable for enhancements in healthcare quality, cost-control, affordability, and access. Additional external pressures are also being placed on the health system to improve quality and reduce cost as well. For example, the Centers for Medicare and Medicaid Services has announced the imposition of value based purchasing and quality-based incentives and penalties for hospitals, which currently are focused on reduced readmissions, hospital acquired conditions, patient satisfaction and literally dozens of metrics which tie quality to reimbursement. Because the hospitals do not segregate populations as they work to comply with these mandates, all patients, regardless of payer, benefit from these efforts. Commercial, Managed Medicaid, and Medicare Advantage contracts are also significantly invested in pay-for-performance, and, in addition to active supervision, the New Health System will be held, through financial incentives and penalties, to achieving the objectives agreed to by the payer and the system. In addition, for the New Health System to achieve the expenditure commitments being made in the Application, pressure will exist to achieve the synergies committed in the Application. Significant competition will remain from large tertiary systems located nearby requiring the New Health System to continue to behave competitively to attract patients. Competition will remain locally in the outpatient marketplace. As a locally governed enterprise, accountability to the community will be an important advantage over the elimination of local governance which would occur if one or both of the Parties were to join out-of-market systems based elsewhere.

Therefore, as courts have recognized, the major changes occurring in the health care landscape require health systems to behave differently and to be responsive to these payer and government imposed performance standards. The consolidations occurring due to the merger better enable the system to achieve these objectives through improved efficiency, lower cost, and a refocusing of resources on the clinical integration necessary for success.

Recommendation: In order to prevent the New Health System from adversely impacting the quality, availability and price of healthcare services, the Parties have proposed that the following commitments be included in the COPA and be actively supervised by the State:

1. *The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.*

How this commitment would prevent the potential disadvantage: In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. This commitment ensures that the three hospitals which have traditionally served as the hubs for high-level services, Johnson City Medical Center, Bristol Regional Medical Center and Holston Valley Medical Center, will remain available as tertiary referral centers to the patient population. This commitment would be actively supervised by requiring the New Health System to file an

annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

2. *Maintenance of open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors*

How this commitment would prevent the potential disadvantage: Under the current competitive system, patient choice is limited by restrictions on employed physicians' ability to practice at competing system's hospitals in the Geographic Service Area. With some exceptions, Wellmont-employed physicians are not allowed medical staff privileges at certain Mountain States hospitals and Mountain States-employed physicians are not allowed medical staff privileges at certain Wellmont hospitals. This is particularly true in highly competitive specialties such as cardiology. This practice exists because of competitive factors and does not support convenient access for patients. Not only will the New Health System maintain open medical staffs at all facilities, which allows patients to choose a physician and hospital based on their preferences and needs, but employed physicians will now be able to practice at all facilities within the New Health System subject to the rules and conditions of the organized medical staff of each facility. A commitment to maintaining an open medical staff at all facilities will ensure availability to all qualified employed, contracted or independent physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

3. *For all Principal Payers, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement; and, for subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health*

System and a Principal Payer are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.

How this commitment would prevent the potential disadvantage: Without a commitment to cap rate increases, the New Health System could potentially use any marketing and bargaining power achieved through the merger to increase rates for payers and consumers. In order to prevent any potential disadvantage that may result for the patients and payers in the price of healthcare services, the Parties have proposed an initial rate reduction followed by a rate cap commitment to be supervised by the State. Reducing existing commercial and Medicare Advantage contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System will lead to a reduction of prices for consumers and payers below that which is currently agreed to in contracts between Wellmont and its payers and Mountain States and its payers. The commitment of not increasing hospital, non-hospital and physician services rates greater than their respective Consumer Price Index minus 0.25% will bend the price curve, acting as a maximum cap on price growth always lower than the national average. To ensure this commitment is implemented, the State would actively supervise the rate cap implementation and the New Health System would be required by the State to file an annual report attesting to compliance and the State would have the ability to enforce this commitment under the COPA.

4. *The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.*

How this commitment would prevent the potential disadvantage: Many of the commitments in the Application will allow the New Health System to achieve success as federal, state and commercial payers increase their use of value-based payment. Among others, these include a common IT platform, more concentrated volumes, a goal of top decile performance, and a commitment to move toward risk-based models. Without the transaction, and with decreasing volumes and use rates (and thus an increasing inability to financially support many of the hospitals), it will simply be more difficult for these hospitals to achieve the objectives of the government and commercial payers.

To ensure that a reduction in competition between facilities does not decrease the incentive for increased quality and value of care, the Parties have committed to seeking out the alignment of reimbursements with quality and value measures. Federal and state governments are increasingly tying reimbursement, and reimbursement growth, to performance by measuring quality, patient experience and utilization/total cost of care. Commercial health plans and managed Medicare and Medicaid plans are following Medicare's lead. Not only will increased value based payments limit the ability of the New Health System to increase price based on a dominant market position, these payments will drive the New Health System towards improved quality and enhanced patient experience. Since an increasing number of payers with value-based systems

reward appropriate utilization, it will be difficult for the New Health System to make up lost revenue from the price controls detailed above in Section C.3 by inappropriately increasing utilization. *This commitment ensures that the New Health System will actively pursue quality and value based payments and the State will actively supervise this commitment by requiring the New Health System to report progress toward this goal on an annual basis.*

5. *The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.*

How this commitment would prevent the potential disadvantage: To further ensure that a reduction in competition between facilities does not decrease the quality of care in the region, the Parties have proposed a commitment to report quality measures in a timely and easy to understand manner for use by patients, employers and insurers. Public and proprietary reporting of quality data is increasingly being used by patients, employers and insurers to make decisions about what providers provide the best value. Not only are patients utilizing data on quality to decide what provider to use, employers and insurers are increasingly using similar quality data to decide how to tier or narrow their networks to incentivize the use of high-value providers or to exclude low-value providers all together. This commitment ensures that the New Health System will be held accountable by the State and the public for its quality performance. The State will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis.

(D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

Background: Some may argue that partial integration through a joint venture creates benefits in a less restrictive manner than a merger that poses competition concerns. It is true that the partial integration preserves competition between the parties outside the joint venture, but it also typically generates substantially smaller efficiency and quality benefits than a full merger. Under a COPA, structures are in place to ensure that the merger's benefits continue to outweigh the disadvantages resulting from the loss competition.

Assessment: The potential efficiencies and benefits identified in this Application could not be achieved without the merger and granting of a COPA. Moreover, the commitments relating to pricing, consolidation of services, and standardization of practices and procedures would raise significant antitrust concerns if undertaken together by two independent hospital systems. Alternatives that opponents may consider less restrictive to competition, but produce fewer benefits and several disadvantages than a COPA, are discussed below:

Status Quo. The two systems could continue to compete with each other, which is the status quo. However, in a Geographic Service Area that has one of the lowest Medicare Wage Indices in the country, negligible population growth and contains fourteen Health Professional Shortage Areas,²² the status quo has produced a combined debt service of

²² See <http://www.hrsa.gov/shortage/mua/index.html>.

\$1.5 billion, bond ratings below A grade, and significant restrictions on the availability of capital to invest in the upkeep of existing infrastructure. With a continued decline in the rate of hospital admissions per capita, the status quo alternative is likely to result in significant reductions in staff, services, and rural facilities to maintain operating margins. While maintaining the status quo may be less restrictive to competition, it would not result in any of the benefits that would be made possible by the merger if the COPA is granted. In fact, maintaining the status quo is likely to result in significant disadvantages for the community and the health of the region.

Joint Ventures: Most of the efficiencies identified by the New Health System could not be undertaken under Joint Venture arrangements. Because integration would be partial, not full, meaningful reduction in unnecessary duplication, and the cost-savings and other associated benefits of the merger, would be sharply limited. To the extent there is integration, the Parties would need to share proprietary information, requiring the setting up of complex firewalls and other protections to protect against spillover of competitively sensitive information into areas outside the joint venture. In the past, the Parties have attempted to collaborate with respect to quality improvement methodologies and related projects, but these efforts have been unsuccessful due to the restrictive competitive environment. Specifically, the Parties, as competitors, have been unable to share proprietary information and have lacked a common clinical information system. A joint venture would eliminate the incentive for the Parties to move towards a Common Clinical IT Platform due to the significant investments both Parties have made towards their individual IT systems. Commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would also raise significant antitrust concerns if undertaken together by two independent hospital systems in a joint venture arrangement. The Parties have exhausted their joint venture options in the current competitive market. As a result, the COPA is needed for the Parties to realize the benefits made possible by the merger.

Out-of-Market Merger. Finally, the Parties wish to address the alternative of a merger by either Party with an out-of-market health system. While such a merger with a third-party is not a current alternative, it has been raised by opponents as less restrictive to competition than the merger between Wellmont and Mountain States.

The impetus behind the proposed merger of Wellmont and Mountain States was the independent decision of the Wellmont Board of Directors that Wellmont must merge with another system or be acquired in order to be successful long-term. This decision led to the search for a strategic-partner. The Board of Directors of Mountain States subsequently recognized that if Wellmont merged with an out-of-market entity, Mountain States would need to do the same in order to stay competitive against a better capitalized competitor.

If Wellmont and Mountain States are not allowed to merge under the COPA, both systems would continue their independent searches for partners outside the region. A merger by either Party with an out-of-market system would not require a COPA and would likely not trigger the same antitrust scrutiny. In this case, there is a reasonable concern that a merger by either Party with an out-of-market system could result in price

increases for consumers since the out-of-market partner would be free to leverage any bargaining position without State supervision.²³

Other deleterious effects could result from the merger by either Party with an out-of-market system. Specifically, local governance over health care operations would likely be lost. Well-paying jobs in the region may decrease as corporate business functions would be eliminated locally and centralized out-of-market. Any efficiencies gained from an out-of-market merger would likely be sent out of the region to two new corporate parents instead of being reinvested in public health, behavioral health, and academics and research as the Parties have committed to under the COPA. Finally, a merger with an out-of-market system by either Party would likely result in the potential loss of access to health care in rural areas. As described in the Application, providing services in rural areas is often unprofitable, and it would be very difficult to maintain rural healthcare services in the long term without the commitments made by the two Parties under the COPA. In short, while a merger by either Party with an out-of-network system may be viewed as a less restrictive alternative to the merger of Wellmont and Mountain States, none of the benefits or efficiencies described in the Application would be likely to result from such an out-of-market merger. In fact, the unsupervised merger of either Party with an out-of-market system is likely to result in far more disadvantages for consumers and the community than a merger of Wellmont and Mountain States that is actively supervised by the State.

Recommendation: The many benefits of the merger between Wellmont and Mountain States that are articulated in the Application would not be possible without the non-labor, labor, and clinical efficiencies available as a result of the combination of local resources owned by Wellmont and Mountain States. Since the proposed consolidation of local assets would likely implicate state and federal antitrust laws without a COPA, there is no less restrictive arrangement that would result in the same, or even similar, benefits. The Parties have already exhausted their joint venture opportunities in the current competitive environment. Maintaining the status quo or pursuing a combination with an out-of-market system is likely to result in far more disadvantages to consumers and the community than an actively-state-supervised merger. As a result, there are no arrangements available that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the merger of Wellmont and Mountain States.

The COPA provides a unique mechanism for Wellmont and Mountain States to merge under active state supervision. This structure allows the State to replace competition with regulatory oversight of the New Health System's compliance with the mutually agreed enforceable commitments that benefit the community. Ongoing, active supervision by the State ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the State's policies underlying the issuance of the COPA are fulfilled.

²³See, e.g., Dafny, L., Ho, K., and Lee, R.S. "The Price Effects of Cross-Market Hospital Mergers." Working Paper, 2015 for discussion of these issues.

Exhibit 11

List of Wellmont's Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

CONTRACT LISTING - Less than 2% Net Revenue

CONTRACT	CONTRACTING PARTY
Aetna	PHO
Amera-Net	PHO
American PPO	PHO
Amerigroup	WHS (System)
Anthem Healthkeepers HMO SNF	MVRMC
Anthem Med Advantage SNF	MVRMC
Anthem PAR/PPO SNF	MVRMC
Anthem	Hospice
BCBST TennCare	ASC's
BCBST TennCare	WHS Hospitals
BCBST Medical Service Agreement	Hospice
BCBST TennCare	Hospice
Beacon Health (Value Options)	BRMC/Ridgeview
Beech Street	PHO
Carolina Steel	PHO
Cigna Behavioral Health	BRMC/Ridgeview
Cigna Behavioral Health	WMA - contracts with each behavioral health provider
Commonwealth of VA Dept of Rehab	BR/HV/LPH/MVRMC
Corvel Corporation	PHO
Coventry Healthcare of Virginia	PHO
Coventry National Network	WHS Facilities
Employer's Choice Network	WHS Hospitals in VA
Evolutions Healthcare Systems	PHO
Galaxy Health Network	PHO
HealthNet Federal Services (Veterans)	WHS Hospitals in VA
HealthNet Federal Services (TriCare)	WHS Hospitals in VA
HealthNet Federal Services	WMA
HealthNet Federal Services	WCS
HealthSpring Medicare Advantage	Wexford House
Humana Tricare Prime	WHS Hospitals/Hospice
Humana Tricare	WMA
Humana Tricare	WCS
Integrated Medical Solutions	PHO
INTotal Health	PHO
LifeSynch	WMA
King University	PHO
Magellan Behavioral Health	BRMC/Ridgeview
MCA Level Funding Plan	PHO
MHNet Behavioral Health	BRMC/Ridgeview
Mountain Empire PACE	WHS Hospitals/Hospice
Mountain Empire PACE	WMA
Multiplan	PHO
NovaNet	PHO

Optima Health Medicaid	WHS
Optima Health Medicaid	WMA
Optima Health Medicaid	WCS
Pittston Preferred	PHO
Prime Health Services	PHO
Provider Select	PHO
Scott County School Board	PHO
SelectNet Plus	PHO
Takoma Regional Hospital	PHO
The Initial Group	PHO
The United Company	PHO
TriCare for Life	Wexford House
TriWest Healthcare Alliance	WHS (System)
United Behavioral Health Commercial	BRMC/Ridgeview
United Behavioral Health Commercial	WMA - contracts with each behavioral health provider
United Behavioral Health TennCare	BRMC/Ridgeview
United Behavioral Health TennCare	WMA
UHC Community Plan	WHS Facilities
UHC Community Plan	WMA
UHC Community Plan	WCS
UHC Community Plan	Wexford House
USA MCO	PHO
Veterans Evaluation Services	WHS Hospitals
Virginia Premier	PHO
WellCare Medicare Advantage	PHO
Wellmont Health System	PHO

Exhibit 12

List of Mountain States' Current Insurance Contracts that Represent Less than 2% of Patient Service Revenue

Mountain States Health Alliance

Payers that Represent Less than 2% of Patient Service Revenue

Total Number of Payers 161

Payor	Product	Mountain States Health Alliance Contracting Party
Allied National, Inc.		Mountain States Managed Care, Inc.
Amerigroup Virginia, Inc.	VA Medicaid	ISHN, LLC
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicaid Integration Participation Attachment	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Advantage	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA Home Health - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Integration Participation Attachment	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Blue Ridge
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	Mediserve Medical Equipment, Inc. and Community Home Care, Inc.
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Home Health - VA and Kingsport Home Health

Payor	Product	Mountain States Health Alliance Contracting Party
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA Hospice - VA and Kingsport Home Health
Anthem Health Plans of Virginia, Inc.	Medicare Medicaid Dual Integration	MSHA SNF - NCH & SCCH
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Johnston Memorial Hospital; Dickenson Community Hospital; Norton Community Hospital; Smyth County Community Hospital; Mountain States Health Alliance d/b/a Russell County Medical Center, and Mountain States Health Alliance d/b/a Indian Path Medical Center
Anthem Health Plans of Virginia, Inc.	Medicare	Blue Ridge
Anthem Health Plans of Virginia, Inc.	VA Medicaid	Blue Ridge
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	HMO Medicaid Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Advantage Participation Attachment – Non-Acute	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield	Medicare Medicaid Dual Integration	Kingsport Ambulatory Surgery Center, LLC and Johnston Memorial Hospital dba Johnston Memorial Ambulatory Surgery Center
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Dickenson Community Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Johnston Memorial Hospital
Appalachian Agency for Senior Citizens	AllCare for Seniors	Mountain States Health Alliance d/b/a Russell County Medical Center
Appalachian Agency for Senior Citizens		Dickenson Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Hospital
Appalachian Agency for Senior Citizens		Norton Community Physician Services Corporation
Appalachian Agency for Senior Citizens		Mountain States Health Alliance dba Russell County Medical Center

Payor	Product	Mountain States Health Alliance Contracting Party
Appalachian Agency for Senior Citizens		Russell County Medical Center dba Riverside Community Medical Clinic
Beech Street Corporation		Mountain States Health Alliance
Beech Street Corporation		Blue Ridge Medical Management
Beech Street Corporation		APP
Benefit Plan Administrators, Inc.		Smyth County Community Hospital
Benefit Resources, Inc.		Russell County Medical Center
Blue Ridge Job Corp Center		Smyth County Community Hospital
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (BRMMC)
BlueCross BlueShield of Tennessee Inc.	Dual Eligible Special Needs Plan	Participating TennCare Provider (Facilities and KDS)
Bluegrass Family Health, Inc.		Unicoi County Memorial Hospital
CareCentrix		Mountain States Health Alliance dba MCHC
Centurion		Mountain States Health Alliance
CHA Provider Network, Inc.		Norton Community Hospital
Christian Care Centers of Johnson City, Inc.		Mountain States Health Alliance
CIGNA Behavioral Health, Inc.		Mountain States Health Alliance
Commonwealth of Virginia Department of Health, Office of Family Heath Services		Smyth County Community Hospital
Commonwealth of Virginia Department of Rehabilitative Services		Smyth County Community Hospital
Commonwealth of Virginia, Department of Mental Health, Mental Retardation and Substance Abuse Services		Smyth County Community Hospital
Commonwealth of Virginia, Virginia Department of Health, Cumberland Plateau Health District	Breast & Cervical Cancer Program	Russell County Medical Center
Comp Management of Virginia, Inc.		Norton Community Hospital
Corphealth, Inc. d/b/a LifeSynch	Psych Commercial	Facility and Physician
Corvel Healthcare Corporation	Corvel Commercial/WC	Mountain States Health Alliance
Corvel Healthcare Corporation	Corvel Commercial/WC	Kingsport Ambulatory Surgery Center, LLC dba Kingsport Day Surgery
Corvel Healthcare Corporation	Physician Agreement - Commercial/WC	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Cumberland Mountain Community Services, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers Community Services, New River Valley Community Services, Planning District 1 Behavioral Health Services	Psychiatric Service Agreement	Russell County Medical Center
Dickenson County Behavioral Health Services	Behavioral Health Services Agreement	Russell County Medical Center
Division of Rehabilitation Services of the Tennessee Department of Human Services		Mountain States Health Alliance
Evalumed		Not specified; mentions "Mountain States Health Alliance physical therapist" and "Managed Care"
First Health Group Corp.		Mountain States Health Alliance - TN Facilities
First Health Group Corp.		Norton Community Hospital
Fortified Provider Network		Johnston Memorial Hospital
Frontier Health, Inc./PD 1	Psychiatric	Russell County Medical Center
Galaxy Health Network		Russell County Medical Center
Galaxy Health Network		Unicoi County Memorial Hospital
Gateway Health Alliance, Inc.		Dickenson Community Hospital, Norton Community Hospital, Smyth County Community Hospital, Mountain States Health Alliance d/b/a Russell County Medical Center (includes rates for facility and physician)
Gateway Health Alliance, Inc.		Southwest Virginia Health Network - JMH PHO(includes rates for both physicians and facility)
Grayson Nursing & Rehabilitation Center- Skilled Nursing Facility		Smyth County Community Hospital, Inc.
Health Payors Organization, LTD.		Johnson City Medical Center Hospital, Inc.
Highlands Community Services	Psychiatric	Russell County Medical Center
Holston Distributing Inc	Ancillary Agreement - WC	Mountain States Health Alliance
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Sycamore Shoals Hospital
Horizon Health EAP Services, Inc.		Mountain States Health Alliance dba Johnson City Medical Center (dba Woodridge Psychiatric Hospital)

Payor	Product	Mountain States Health Alliance Contracting Party
Horizon Health EAP Services, Inc.		Blue Ridge Psychiatry/Woodridge Hospital Physicians
Hospice of Southwest Virginia		Smyth County Community Hospital
Humana Government Business, Inc. d/b/a Humana Military		Mountain States Health Alliance (Unicoi Locations)
Humana Health Plan, Inc.	Commercial	Mountain States Health Alliance
Humana Insurance Company, Humana Health Plan, Inc.	Commercial	Blue Ridge Medical Management
Humana Military Health Services, Inc.		Mountain States Health Alliance
Integrated Medical Solutions, LLC	USP Lee County	Mountain States Health Alliance (IPMC & NCH)
INTotal Health, LLC (formerly known as Amerigroup Virginia, Inc.)	VA Medicaid	ISHN, LLC - Physicians
ISHN - Optima/Sentara	Optima/Sentara Medicaid	Blue Ridge Medical Management
ISHN - Optima/Sentara	Optima/Sentara Medicaid	Facilities
ISHN - Optima/Sentara		Mountain States Health Alliance (Kingsport Day Surgery Center, Dickenson Community Hospital, Franklin Woods, Indian Path, Johnson City Medical, Woodridge Hospital, Johnson County Community Hospital, Johnston Memorial Hospital, Norton Community Hospital, Russell County Medical Center, Smyth County Community Hospital, Sycamore Shoals, Quillen Rehabilitation, Niswonger Children's Hospital)
ISHN - Optima/Sentara		Blue Ridge Medical Management
Ivy Hall Nursing Home, Inc.		Mountain States Health Alliance
Johnston & Associates, Inc.		Mountain States Health Alliance - WC TN & VA Diagnostic
Johnston & Associates, Inc.		Mountain States Health Alliance - TN WC Rehab
Johnston & Associates, Inc.		Mountain States Health Alliance VA WC Rehab
KDM, Inc. dba Durham-Hensley Health and Rehabilitation		Mountain States Health Alliance
Lakebridge Medical Investors, LLC dba Lakebridge Health Care Center		Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Commercial	Blue Ridge Medical Management Corporation

Payor	Product	Mountain States Health Alliance Contracting Party
Magellan Behavioral Health, Inc.	Medicaid	Blue Ridge Medical Management Corporation
Magellan Behavioral Health, Inc.	Commercial	Mountain States Health Alliance
Magellan Behavioral Health, Inc.	Medicaid	Mountain States Health Alliance
Managed Health Network, Inc.		Russell County Medical Center, Inc.
Medcost, Inc.		Johnston Memorial Hospital
Medical Control Network Solutions, Inc.		Norton Community Hospital
Medical Network, Inc.		Sycamore Shoals
Mental Health Associates, Inc.		ISHN, LLC
Modern Chevrolet		Russell County Medical Center
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital Home Health
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Physicians Services
Mountain Empire Older Citizens, Inc.	PACE	Norton Community Hospital
Mountain Empire Older Citizens, Inc.	PACE	Community Home Care, Norton Community Hospital
MultiPlan, Inc.	Commercial	Blue Ridge Medical Management
MultiPlan, Inc.	Commercial	Facility
MVP Health Plan, Inc., MVP Select Care, Inc. and MVP Affiliates	Medicare PPO	Mountain States Health Alliance and Blue Ridge Medical Management
National Preferred Provider Network, Inc.		Southwest Virginia Health Network (JMH & Physicians)
National Preferred Provider Organization (Unicare)		Russell County Medical Center & Johnston Memorial
Novanet, Inc.	Medical	MSHA Hospitals
Novanet, Inc.	Medical	KDS
Novanet, Inc.	Medical	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians

Payor	Product	Mountain States Health Alliance Contracting Party
Novanet, Inc.	Workers' Comp	BRMMC, Norton Community Physician Services, Abingdon Physician Partners, Dickenson Medical Associates, Dickenson Community Hospital ER Physicians, Smyth County Community Hospital ER Physicians, Smyth County Community Hospital Physicians, Russell County Medical Center ER Physicians, Russell County Medical Center Physicians, Johnston Memorial Hospital Physicians
Novanet, Inc.	Workers' Comp	Kingsport Day Surgery
Novanet, Inc.	Workers' Comp	Mountain States Health Alliance
Optimum Choice, Inc		Russell County Medical Center, Inc.
Physician Services, LC	4Most Health	Facility & Physician
Pittston Coal		Russell County Medical Center
Preferred Care	USA Care Plan	Facility
Prime Health Services, Inc.		Blue Ridge Medical Management Corporation
Prime Health Services, Inc.		Facilities
Private Healthcare Systems, Inc.		Physician
Private Healthcare Systems, Inc.		Mountain States Health Alliance
Public Risk Services, Inc. /The Pool		Mountain States Health Alliance
Roan Highlands Medical Investors, LLC dba Roan Highlands Nursing Center		Mountain States Health Alliance
Russell County Detention Center		Russell County Medical Center
SelectNet Plus, Inc. (Accorida National)		Russell County Hospital
Seven Corners, Inc.	USP Lee County	Mountain States Health Alliance
Southern Health Services, Inc.	VA Medicaid	ISHN, LLC (MSHA & MSMG)
Southwest Virginia Mental Health Institute		Smyth County Community Hospital
State Of Tennessee Department of Health	Tennessee Department of Health, Communicable & Environmental Diseases and Emergency Preparedness, HIV/STD Programs , Ryan White Part B Program	Unicoi County Memorial Hospital
Tennessee Department of Health	Breast and Cervical Screenings	Unicoi County Memorial Hospital
Tennessee Department of Health	CEDEP Program (Ryan White)	Johnson City Medical Center - Facilities to be determined based on vendor forms
Tennessee Department of Health	Mammography Screening Program	Mountain States Health Alliance
The Infant Toddler Connection of Mount Rogers		Smyth County Community Hospital
The Initial Group		APP

Payor	Product	Mountain States Health Alliance Contracting Party
The Initial Group		APP
The Initial Group, Inc.		ISHN, LLC
Three Rivers Provider Network		Hospital Affiliation – Johnston Memorial Hospital
Three Rivers Provider Network, Inc.		JMH physicians
TriWest Healthcare Alliance Corp.		Mountain States Health Alliance
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Mountain States Health Alliance d/b/a Russell County Medical Center Home Health
Trustees of the UMWA 1992 (and 1993) Benefit Plan;		Norton Community Hospital
Trustees of the United Mine Workers of America Combined Benefit Fund, the Trustees of UMWA 1992 Benefit Plan , the Trustees of the UMWA 1993 Benefit Plan and the Trustees of the UMWA Prefunded Benefit Plan		Mountain States Health Alliance dba Russell County Medical Center
UMWA Health and Retirement		Mountain States Managed Care, Inc. (TN Facilities)
United Behavioral Health, Inc.	Commerical & Medicare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Behavioral Health, Inc.	TennCare	Mountain States Health Alliance d/b/a Sycamore Shoals Hospital and Woodridge Psychiatric Hospital
United Mine Workers of American, Combined Benefit Fund, UMWA 1992 Benefit Plan, UMWA 1993 Benefit Plan		Blue Ridge Medical Management Corporation
United Payors and United Providers, Inc.		Sycamore Shoals, Quillen, Franklin Woods and KDS
USA Health Network Company, Inc.		JMH
USA Health Network Company, Inc.		JMH Physicians
USA Managed Care Organization, Inc.		Norton Community Hospital
USA Managed Care Organization, Inc.		Smyth County Community Hospital
USA Managed Care Organization, Inc.		Mountain States Health Alliance
USA Managed Care Organization, Inc.		APP
Value Options, Inc.	Commerical	Mountain States Health Alliance dba Woodridge Psychiatric Hospital and Sycamore Shoals

Payor	Product	Mountain States Health Alliance Contracting Party
Value Options, Inc.	TriCare Provider Agreement	Mountain States Health Alliance dba Woodbridge Psychiatric Hospital
Virginia Department of Health	Sterilization Program	Smyth County Community Hospital
Virginia Department of Health, Mount Rogers health district	Virginia Department of Health Office of Purchasing and General Services Standard Contract - Every Women's Life	Johnston Memorial Hospital, Inc.
Virginia Health Network, Inc.		Mountain States Health Alliance & Physicians
Virginia Premier Health Plan, Inc.		ISHN, LLC - Base Agreement (Facilities & Physicians)
Windsor Health Plan, Inc.		Unicoi County Memorial Hospital, Inc. & Nursing Home

Exhibit 13

Mountain States' Currently Planned Fixed Rate Increases

To be submitted pursuant to CID.

Exhibit 14

Wellmont's Currently Planned Fixed Rate Increases

To be submitted pursuant to CID.

Exhibit 15

Mountain States' Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology
Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient
Services

To be submitted pursuant to CID.

Exhibit 16

Wellmont's Negotiated Rate Increases for the Past Five Years Calculated using the Same Methodology Proposed in the Commitment to Not Increase Negotiated Rates for Hospital, Physician, or Non-Hospital Outpatient Services

To be submitted pursuant to CID.

Exhibit 17

Anticipated 10-Year Timeline

d. Common Clinical IT and Health Information Exchange	Year 1				Year 2				Year 3				Year 4				Year 5				Year 6				Year 7				Year 8				Year 9				Year 10			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4																																
<i>Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10</i>																																								
i. System Integration 18-24 months																																								
Assessment of Health Systems including vendor		X	X																																					
System Implementation with data conversion and 3rd party interfaces				X	X	X	X	X	X	X	X	X																												
Training all Users (employed & non-employed providers)									X	X	X	X																												
1. Behavioral Health Capability																																								
EMR systems include:																																								
- Standardized screening questionnaires & assessment tools																																								
- Clear and consistent documentation protocols																																								
- Treatment plans, flowsheet & restraint documentation																																								
- Suicide intervention tools																																								
Integration and interoperability follows the standard for an integrated EMR, which is fully integrated and interoperable.																																								
EMR system will have future development for a behavioral health module																																								
2. Integration																																								
Large EMRs interface with over fifty 3rd party vendors, linking records, integrating lab, medical, diagnostic, referral, and scheduling. Interfaces are inbound and outbound, to and from vendors, providers, government entities, etc.																																								
3. Migration of Historical Data																																								
Historical data such as medications, allergies and problems lists are generally converted to the new system. The remaining historical data will be accessible through a link inside the EMR to an archiving system such as DataArk (used at Wellmont.)																																								
4. Training of New Users																																								
All employed and non-employed providers are required to attend a minimum of 8 hours classroom training and pass a test to gain access to the EMR. Surgeons /proceduralists/specialists require additional training time. Training is specialty specific and includes a personalization lab.																																								
5. Patient Portal Access																																								
5.1 Medications, allergies, problem list, immunization records, test results, visit/admission summaries, e-visits, billing information with the capability to pay online as well as patient engagement: such as clinical offerings to healthy behavior classes, research studies, patient education are available through a patient portal.																																								
5.2The patient portal also links to other vendor enabled health systems.																																								
5.3 Patients have access to reconciled health care data from different health systems.																																								
6. Collecting, Analyzing and Reporting Quality Outcomes																																								
Data is sent monthly to various analytical companies including Crimson, Comparison and CMS providing statistical analysis for clinical cost, quality, and patient satisfaction for both system and non system providers.																																								

Exhibit 18

Estimates for How and When the \$150 Million Investment in a Common Clinical IT Platform and Health Information Exchange will be Allocated

Exhibit 19

Current Commitment and Timeframe for Participation of both MSHA and Wellmont in OnePartner

RESPONSE:

▪ ***Description of the health information exchanges ("HIE") currently used by each party***

○ Wellmont

- Wellmont is currently an acute data contributor to OnePartner.
- As an acute data contributor, Wellmont provides the following information to OnePartner:
 - Demographics
 - Encounters
 - Labs
 - Diagnoses
 - Procedures and
 - Radiology.
- The initial cost to set up the interface with OnePartner was \$63,500.
- There are annual fees of \$9,800 for Wellmont to continue sending information to OnePartner.
- The cost for each provider to be able to access the information in the HIE is \$149 per physician per month.
- As of July, 2016, a group of Wellmont physicians have access to OnePartner as collaborators rather than simply contributors.
- The only patient information available within the HIE is the 18 data points identified below. The patient information can be viewed and printed when the provider is accessing the HIE.

• Mountain States

- Mountain States is currently an acute data contributor to OnePartner under a five year agreement set to expire on December 31, 2019.
- As an acute data contributor, Mountain States provides the following information to OnePartner:
 - Demographics
 - Encounters
 - Labs
 - Diagnoses
 - Procedures and
 - Radiology.
- Clinical documents are scheduled to go-live in July 2016. For acute hospitals the clinical documents will include history and physical, progress notes (SOAP), consults, procedure notes, and discharge summaries. For ambulatory surgery centers, the clinical documents will include office visit assessments, post- op visit notes, ER follow up notes, and prenatal visit notes.
- Mountain States Medical Group is currently testing ambulatory data on-boarding with OnePartner and will be complete by the end of August 2016. Once on-board, Mountain States Medical Group is expected to provide

Demographics, Encounters, Vitals, Labs, Diagnoses, Procedures, Problems, Allergies, Medications, Immunizations, Clinical Documents to OnePartner for all patients treated by the Group's 375 providers and mid-levels.

- Mountain States' current financial commitment to OnePartner is \$98,000.
- Initial setup cost to connect to OnePartner was \$53,500. Mountain States pays \$8,900 per year for five years for access to the OnePartner data.
- In addition to exchanging 11,432,731 data transactions with OnePartner, Mountain States has had a broad range of experiences with data sharing arrangements.
- Currently, other data sharing partners include:
 - State of Franklin Health Associates : 373,673 data transactions
 - Inpatients Consultants: 289,760 data transactions
 - Medical Practice Management: 162,384 data transactions
 - East Tennessee State University: 69,502 data transactions.
- Mountain States also currently send Immunization data, and is in final testing for exchanging Syndromic Surveillance data, to the state of Tennessee. In addition, Mountain States currently sends Immunization and Syndromic Surveillance data to the Virginia Connect HIE.
- Mountain States was a Veterans Administration proof of concept, pilot and demonstration partner in the development of the Direct Messaging platform and has recently undertaken initial conversations with the Veterans Administration for potential inclusion with their Virtual Lifetime Electronic Record (VLER) program.
- Finally, Mountain States is actively working with Tennessee's Healthcare Innovation Initiative to develop a community case management tool.

- ***Description of the OnePartner HIE***

- OnePartner is a for-profit limited liability company owned by physicians in northeast Tennessee.
- OnePartner is exclusively a physician Regional Health Information Exchange available to providers located in Northeast Tennessee and Southwest Virginia.
- It is operationalized through the use of a product named dbMotion. dbMotion is a context aware computer application that when deployed and integrated with a OnePartner collaborator's EMR, provides access to the OnePartner patient record from the practicing physician's EMR workstation.
- Access to OnePartner is available through an online portal: <https://provider.onepartnerhie.com>.
- Before accessing the OnePartner HIE data, a participating entity must sign a collaborator agreement, meet the criteria in the agreement, pay a subscription fee of \$150-200 per month per provider, and meet the minimum standards for participating providers. They must also sign a Business Associate Agreement and a Data Sharing Agreement.
- The information fields available in the OnePartner HIE are limited to the following:

- Name
 - Demographics
 - Active Allergies
 - Current Medications
 - Problem List (Current Problems)
 - Problem List (Resolved Problems)
 - Recent Visits
 - Immunizations
 - History (Medical and Surgical)
 - History (Family)
 - History (Social)
 - Last Recorded Vital Signs
 - Progress Notes
 - Plan of Care
 - Functional Status
 - Recent Results
 - PCP
 - Custodial/Source Organization
- These 18 components are sent to the HIE unless a patient affirmatively opts-out and requests that their information not be included.
 - Once on the system, HIE data can be printed and can be brought into the participating entity's EMR only if they have certain computer capabilities on their end.
 - According to OnePartner, over the last four years:
 - the number of providers providing data is currently greater than 1,000
 - the number of providers viewing data is approximately 400
 - there are 654,083 unique patients have been entered into the database.
 - Based on information provided by OnePartner, the top contributing providers are Mountain States, Holston Medical Group, and State of Franklin Health Associates.
 - Again, based on information provided by OnePartner, the top accessors of data are Holston Medical Group, State of Franklin Health Associates, and Qualuable Medical Professionals.

Exhibit 20

Additional Detail on the Proposed Community Reinvestment

Below is a description of the activities to be funded by the proposed community reinvestment by category. It should be noted that the timing of spending for each category is an estimate and may vary depending upon market circumstances. Also, some spending may cross into multiple categories. For example, as noted below, pediatric sub-specialty access may include specific mental health services. As a result, it has not yet been determined which category would be “credited” with that expenditure.

The \$75 million investment in population health improvements:

RESPONSE: Additional detail on this incremental investment is provided in the proposed template Community Health Improvement Plan included separately as [Exhibit 21](#) and the annual estimate of reinvestment from efficiencies, also provided separately as [Exhibit 22](#). As explained in the Application, the Parties believe that including the Department, the local departments of health, the Community Health Work Groups, the Advisory Groups, and other community stakeholders in finalizing the proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Once the community health improvement goals are agreed upon with the state under the COPA, the exact programmatic investments – including location and timing – will be determined in order to most effectively leverage existing programs which operate successfully in the region and fill gaps in service offerings and funding needs where existing programs do not adequately cover the community health needs.

The \$140 million to expand needed services:

RESPONSE: The \$140 million spending referenced in the Application falls into three major categories: mental health and addiction recovery (\$85 million), pediatric sub-specialty access (\$27 million) and rural health access (\$28 million). Additional detail on the incremental investment for these services is provided in the proposed template Community Health Improvement Plan included separately as [Exhibit 21](#). Annual spending estimates for these services are included in the annual estimate of reinvestment from efficiencies that is included separately as [Exhibit 22](#). These latter two categories of spending, pediatric sub-specialty access and rural health access, will support the provision of new services which would not otherwise generate sufficient revenue for the New Health System to offer, but are necessary to address specific health and health care needs and reduce patient travel time. These expenditures will be guided by physician needs assessments updated every three years in each sub-market within the Geographic Service Area.

The \$85 million to develop and grow academic and research opportunities:

RESPONSE: Additional detail on the spending associated with academic and research opportunities is provided in the annual estimate of reinvestment from efficiencies, provided separately as [Exhibit 22](#). In regard to the sub-categories of spending on research infrastructure, increasing residency and training slots, creating new specialty training opportunities, and adding faculty—the Parties believe these plans must be developed together with their academic partners in Tennessee and Virginia. This process will include the development of a ten-year plan

for post-graduate training of physicians, nurse practitioners, and physician assistants along with other allied health professions. The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a ten-year plan for investment in health research and growth in the health research enterprise within the region. It is not possible for the Parties to develop these plans without the integral involvement of their academic partners in Tennessee and Virginia, and the Parties expect this process will take at least a year for these plans to be fully developed.

Strategically, a major part of the New Health System's emphasis will be on the development of academic research infrastructure and personnel which is needed to attract additional research funding from national sources—specifically in the area of translational research. The New Health System intends to allocate resources to priority research projects identified by the New Health System and academic partners in pursuit of this goal. Translational research projects that are focused on rural health care, population health management, health care transformation, and community health improvement will offer important insights to inform the New Health System's overall efforts in the region and to create national models.

Further, the Parties will focus on developing the academic infrastructure to ensure effective training for the next generation of health professionals that are needed to address the health care needs of this region. This will require a program gap analysis and the formation of program development plans. In addition, the Parties will work to identify fellowship training opportunities to support the regional base of sub-specialty physicians along with collaboration where professors and research leaders can work together to close gaps in regional specialty services or provide clinical oversight. The Parties expect that an offshoot of these comprehensive efforts will be the development of new medically and technically oriented businesses in the region, and the Parties plan to work with municipalities and economic development agencies to help incubate these opportunities and attract new opportunities to the region to support the regional economy.

Exhibit 21

Template Community Health Improvement Plan

Template Community Health Improvement Plan

Ensure Strong Starts for Children 1/2	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Reduce Childhood Obesity		Reduction in percent children classified as “overweight”	X	X	X		
<ul style="list-style-type: none"> • Increase rates of breastfeeding <ul style="list-style-type: none"> ▪ Program Example: <i>Baby Friendly Hospital Initiative</i> 	Increased rate of breastfeeding at 6 months		X	X	X		X
<ul style="list-style-type: none"> • Increase physical activity <ul style="list-style-type: none"> ▪ Program Example: <i>Morning Mile; Project SPARK</i> 	Increased rate of children achieving the recommend level of weekly physical activity		X	X	X		
<ul style="list-style-type: none"> • Increase healthy eating <ul style="list-style-type: none"> ▪ Program Example: <i>#LiveSugarFreed campaign</i> 	Decreased amount of weekly sugary beverage consumption in children		X	X	X		
Decrease Tobacco Use in Youth		Decreased rates of “current” use of tobacco	X	X	X	X	X
<ul style="list-style-type: none"> • Expand anti-smoking campaigns <ul style="list-style-type: none"> ▪ Program Example: <i>#UNSMOKABLE</i> 	Reduced rate of past year smoking initiation or “ever” smoked		X	X	X	X	X
Decrease Opioid Abuse in Youth		Decreased reported past month non-medical use of pain relievers				X	X
<ul style="list-style-type: none"> • Decrease diversion <ul style="list-style-type: none"> ▪ Program Example: <i>Drug return kiosks</i> 	Milligrams of prescription painkillers removed from circulation					X	X
<ul style="list-style-type: none"> • Expand anti-opioid campaigns <ul style="list-style-type: none"> ▪ Program Example: <i>Above the Influence</i> 	Reduced rate of “ever” tried					X	X
Increase 3rd Graders reading at Grade Level		Increased percentage of 3rd graders scoring “proficient” on TCAP reading assessment	X	X	X	X	X
<ul style="list-style-type: none"> • Increase read aloud opportunities <ul style="list-style-type: none"> ▪ Program Example: <i>Bear Buddies; Nurse Family Partnership</i> 	Increased percentage of “at-risk” K-2 students paired with a Bear Buddy reading mentor		X	X	X	X	X

Template Community Health Improvement Plan

Ensure Strong Starts for Children 2/2	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Decrease Pre-term Births		Decreased pre-term birth rate				X	X
<ul style="list-style-type: none"> • Increase effectiveness of pre-natal care <ul style="list-style-type: none"> ▪ Program Example: <i>Nurse Family Partnership; Centering Pregnancy; 17-P utilization</i> 	Increased percentage high-risk women participating in program					X	X
<ul style="list-style-type: none"> • Decrease tobacco use among pregnant women <ul style="list-style-type: none"> ▪ Program Example: <i>ACOG 5 As Behavioral Intervention; Baby and Me; SMART Moms</i> 	Increased percentage of pregnant female participants completing nicotine abstinence programs					X	X
<ul style="list-style-type: none"> • Decrease NAS births <ul style="list-style-type: none"> ▪ Program Example: <i>Residential treatment for opioid addicted pregnant women</i> 	Decreased percentage of births with NAS					X	X
<ul style="list-style-type: none"> • Increase birth spacing <ul style="list-style-type: none"> ▪ Program Example: <i>Post-partum LARC insertion</i> 	Increased average/median months between pregnancy in high-risk women					X	X

Template Community Health Improvement Plan

Help Adult Live Well in the Community	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Decrease Adult Obesity		Decreased adult obesity rate	X		X		
<ul style="list-style-type: none"> • Increase Physical Activity <ul style="list-style-type: none"> ▪ Program Example: <i>YMCA Diabetes Prevention Program</i> 	Decreased percentage of adults reporting no physical activity within past month		X	X	X		
<ul style="list-style-type: none"> • Increase Healthy Eating <ul style="list-style-type: none"> ▪ Program Example: <i>YMCA Diabetes Prevention Program</i> 	Improvement in the Healthy Eating Index measure of dietary quality		X	X	X		
Decrease Adult Tobacco Use		Decreased rates of “current” tobacco use	X	X	X	X	X
<ul style="list-style-type: none"> • Increase cessation treatment <ul style="list-style-type: none"> ▪ Program Example: <i>Screening and Physician Counseling</i> 	Improved score on tobacco-related HEDIS measures in the New Health System.		X	X	X	X	X
<ul style="list-style-type: none"> • Expand successful mass-reach health communication interventions <ul style="list-style-type: none"> ▪ Program Example: <i>CDC’s Tips From Former Smokers</i> 	Increased population awareness in anti-smoking awareness and attitudes over survey baseline		X	X	X	X	X
Increased Early Detection of Chronic Disease		Decreased early mortality from heart disease, diabetes, suicide, cancer, infant mortality	X	X	X	X	X
<ul style="list-style-type: none"> • Increase population screening <ul style="list-style-type: none"> ▪ Program Example: <i>Screening and Physician Counseling; SBIRT; Mobile Health Unit Deployment</i> 	Improved score on screening-related HEDIS measures in the New Health System.		X	X	X	X	X

Template Community Health Improvement Plan

Promoting a Drug Free Community	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Decrease Opioids In Circulation		Decreased reported past month non-medical use of pain relievers				X	X
<ul style="list-style-type: none"> • Decrease prescriptions written <ul style="list-style-type: none"> ▪ Program Example: <i>Choosing Wisely, CSMD</i> 	Decreased morphine equivalents prescribed					X	X
Expand Environmental Prevention Strategies		Decreased reported past month non-medical use of pain relievers				X	X
<ul style="list-style-type: none"> • Increase multi-sector community collaborations <ul style="list-style-type: none"> ▪ Program Example: <i>Tennessee Community Prevention Coalitions</i> 	Increased number of counties in the GSA with an active Community Prevention Coalition					X	X
Expand supportive services		Decreased reported past month non-medical use of pain relievers				X	X
<ul style="list-style-type: none"> • Increase supportive housing <ul style="list-style-type: none"> ▪ Program Example: <i>Oxford House</i> 	Expanded number of units available in drug-free supportive housing.					X	X

Template Community Health Improvement Plan

Decrease Avoidable ED Use for High-Need High-Utilization Uninsured Individuals	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Increase use of ED alternatives		Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population	X	X	X	X	
<ul style="list-style-type: none"> • Increase use of primary, BH and specialty-care services <ul style="list-style-type: none"> ▪ Program: <i>Project Access, Free-clinics</i> 	Increased utilization of primary care and specialty services by High-Need High-Risk population		X	X	X	X	
<ul style="list-style-type: none"> • Increase use of home-based health services <ul style="list-style-type: none"> ▪ Program Example: <i>Community Paramedics, Community Health Workers</i> 	Increased utilization of home-based health services by High-Need High-Risk population		X	X	X	X	
Expand supportive services		Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population	X	X	X	X	
<ul style="list-style-type: none"> • Increase use of case management <ul style="list-style-type: none"> ▪ Programs example: <i>SC Medicaid Healthy Outcomes Program</i> 	Increased percentage of High-Need High Utilizing population in active case management		X	X	X	X	
<ul style="list-style-type: none"> • Decrease transportation barriers <ul style="list-style-type: none"> ▪ Programs example: <i>Transportation vouchers</i> 	Decrease “no-show” rate in High-Need High Utilization population		X	X	X	X	

Template Community Health Improvement Plan

Improve Access to Behavioral Health	Short-term Outcomes	Intermediate Outcomes	Long-term Expected Health Impact				
			Heart	Cancer	Diabetes	Behavioral Health	Infant Mortality
Increased Screening for Depression and Substance Abuse		Increased use of behavioral health treatment services				X	X
<ul style="list-style-type: none"> • Increased screening at sites of care <ul style="list-style-type: none"> ▪ Program Example: <i>SBIRT</i> 	Increase in the rates of SBIRT administration					X	X
Reduce Unnecessary Psychiatric Admissions		Decreased psychiatric ER and inpatient admissions.				X	X
<ul style="list-style-type: none"> • Expand community based outpatient treatment <ul style="list-style-type: none"> ▪ Program Example: <i>Assertive Community Treatment</i> 	Increase in the percentage of individuals with SMI/SUD participating in community-based treatment					X	X
<ul style="list-style-type: none"> • Expand crisis management services <ul style="list-style-type: none"> ▪ Program Example: <i>Mobile Crisis Teams</i> 	Increase in the percentage of crisis calls responded to by crisis management teams versus law enforcement					X	X
Increase number of individuals with SUD in recovery		Increase in the percentage of individuals participating in active recovery				X	X
<ul style="list-style-type: none"> • Expand continuum of treatment options <ul style="list-style-type: none"> ▪ Program Example: <i>Medically Monitored Detox, Residential Treatment, Outpatient Treatment</i> 	Increase in the capacity in full continuum of treatment services for individuals living with SUD					X	X

Exhibit 22

Year-by-Year Summary

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Health Care Services	Behavioral Health Services	\$ 1,000,000	\$ 4,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 85,000,000
	Children's Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	27,000,000
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	28,000,000
Health Research & Graduate Medical Education	Academics & Research	3,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	85,000,000
Community Health Improvement	Strong Starts for Children; Helping Adults Live Well; Supporting a Drug Free Community; Decreasing High Utilization by the Uninsured	1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	75,000,000

\$ 300,000,000

Exhibit 23

Audited Financial Statement on MSHA as of June 30, 2015

MOUNTAIN STATES HEALTH ALLIANCE

**Audited Consolidated Financial Statements
(and Supplemental Information)**

Years Ended June 30, 2015 and 2014



MOUNTAIN STATES HEALTH ALLIANCE

Audited Consolidated Financial Statements (and Supplemental Information)
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

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INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mountain States Health Alliance:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatements, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Alliance's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and its subsidiaries as of June 30, 2015 and 2014, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

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

Peering Yerhley: Assaats PC

Knoxville, Tennessee
October 28, 2015

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets *(Dollars in Thousands)*

	<i>June 30,</i>	
	<i>2015</i>	<i>2014</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 79,714	\$ 59,185
Current portion of investments	19,598	25,029
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$73,805 in 2015 and \$47,853 in 2014	162,256	161,318
Other receivables, net	33,286	45,502
Inventories and prepaid expenses	33,969	30,838
TOTAL CURRENT ASSETS	328,823	321,872
INVESTMENTS, less amounts required to meet current obligations	694,542	648,475
PROPERTY, PLANT AND EQUIPMENT, net	847,089	881,429
OTHER ASSETS		
Goodwill	156,596	156,613
Net deferred financing, acquisition costs and other charges	24,755	25,841
Other assets	53,040	48,350
TOTAL OTHER ASSETS	234,391	230,804
	<u>\$ 2,104,845</u>	<u>\$ 2,082,580</u>

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Dollars in Thousands)

	<i>June 30,</i>	
	<i>2015</i>	<i>2014</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 18,159	\$ 18,648
Current portion of long-term debt and capital lease obligations	40,286	30,618
Accounts payable and accrued expenses	100,301	87,126
Accrued salaries, compensated absences and amounts withheld	72,066	72,181
Estimated amounts due to third-party payers, net	4,781	10,463
TOTAL CURRENT LIABILITIES	235,593	219,036
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	1,031,661	1,075,069
Estimated fair value of derivatives	2,541	10,603
Estimated professional liability self-insurance	8,461	8,957
Other long-term liabilities	38,683	35,974
TOTAL LIABILITIES	1,316,939	1,349,639
COMMITMENTS AND CONTINGENCIES - Notes D, F, G, and M		
NET ASSETS		
Unrestricted net assets		
Mountain States Health Alliance	583,287	541,979
Noncontrolling interests in subsidiaries	191,118	178,547
TOTAL UNRESTRICTED NET ASSETS	774,405	720,526
Temporarily restricted net assets		
Mountain States Health Alliance	13,303	12,204
Noncontrolling interests in subsidiaries	71	84
TOTAL TEMPORARILY RESTRICTED NET ASSETS	13,374	12,288
Permanently restricted net assets		
	127	127
TOTAL NET ASSETS	787,906	732,941
	\$ 2,104,845	\$ 2,082,580

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2015</i>	<i>2014</i>
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 1,116,954	\$ 1,046,767
Provision for bad debts	(127,519)	(122,642)
Net patient service revenue	989,435	924,125
Premium revenue	32,184	10,683
Net investment gain	17,016	50,703
Net derivative gain	13,890	3,219
Other revenue, gains and support	36,571	62,457
TOTAL REVENUE, GAINS AND SUPPORT	1,089,096	1,051,187
Expenses and losses:		
Salaries and wages	345,155	340,589
Physician salaries and wages	80,279	77,636
Contract labor	5,416	4,282
Employee benefits	77,306	69,173
Fees	120,691	115,606
Supplies	176,050	163,699
Utilities	16,775	17,052
Medical costs	18,383	6,633
Other	81,477	79,980
Loss on early extinguishment of debt	-	4,622
Depreciation	67,210	69,437
Amortization	1,557	1,742
Interest and taxes	43,697	44,392
TOTAL EXPENSES AND LOSSES	1,033,996	994,843
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 55,100	\$ 56,344

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidated Statements of Changes in Net Assets
(Dollars in Thousands)***

Year Ended June 30, 2015

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 41,008	\$ 14,092	\$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478
Repurchases of noncontrolling interests, net	-	(1,014)	(1,014)
Distributions to noncontrolling interests	-	(355)	(355)
INCREASE IN UNRESTRICTED NET ASSETS	41,308	12,571	53,879
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	3,663	69	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	12,558	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	178,631	732,941
NET ASSETS, END OF YEAR	\$ 596,717	\$ 191,189	\$ 787,906

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Changes in Net Assets - Continued
(Dollars in Thousands)

Year Ended June 30, 2014

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
UNRESTRICTED NET ASSETS:			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 48,058	\$ 8,286	\$ 56,344
Pension and other defined benefit plan adjustments	194	194	388
Net assets released from restrictions used for the purchase of property, plant and equipment	3,313	-	3,313
Noncontrolling interest in acquired subsidiary	-	914	914
Distributions to noncontrolling interests	-	(461)	(461)
INCREASE IN UNRESTRICTED NET ASSETS	51,565	8,933	60,498
TEMPORARILY RESTRICTED NET ASSETS:			
Restricted grants and contributions	4,693	88	4,781
Net assets released from restrictions	(5,265)	(56)	(5,321)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	(572)	32	(540)
INCREASE IN TOTAL NET ASSETS	50,993	8,965	59,958
NET ASSETS, BEGINNING OF YEAR	503,317	169,666	672,983
NET ASSETS, END OF YEAR	\$ 554,310	\$ 178,631	\$ 732,941

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2015</i>	<i>2014</i>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Increase in net assets	\$ 54,965	\$ 59,958
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	69,242	71,789
Provision for bad debts	127,519	122,642
Loss on early extinguishment of debt	-	4,622
Change in estimated fair value of derivatives	(7,718)	2,761
Equity in net income of joint ventures, net	(79)	(369)
Loss (gain) on disposal of assets	(2,192)	(3,489)
Amounts received on interest rate swap settlements	(6,172)	(5,980)
Capital Appreciation Bond accretion and other	2,780	2,629
Restricted contributions	(3,732)	(4,781)
Pension and other defined benefit plan adjustments	330	(388)
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(128,457)	(115,380)
Other receivables, net	12,303	(11,880)
Inventories and prepaid expenses	(3,131)	959
Trading securities	(39,873)	(46,451)
Other assets	(3,128)	(2,492)
Accrued interest payable	(489)	(1,058)
Accounts payable and accrued expenses	16,745	(6,666)
Accrued salaries, compensated absences and amounts withheld	(115)	8,006
Estimated amounts due to third-party payers, net	(5,682)	(16,312)
Estimated professional liability self-insurance	(496)	199
Other long-term liabilities	2,379	16,425
Total adjustments	<u>30,034</u>	<u>14,786</u>
NET CASH PROVIDED BY OPERATING ACTIVITIES	84,999	74,744
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of property, plant and equipment and property held for expansion	(44,569)	(64,424)
Acquisitions, net of cash acquired	-	(4,256)
Purchases of held-to-maturity securities	(1,417)	(5,978)
Net distribution from joint ventures and unconsolidated affiliates	4,859	661
Proceeds from sale of property, plant and equipment and property held for resale	2,654	2,858
NET CASH USED IN INVESTING ACTIVITIES	(38,473)	(71,139)

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Cash Flows - Continued
(Dollars in Thousands)

	<i>Year Ended June 30,</i>	
	<i>2015</i>	<i>2014</i>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(36,210)	(38,768)
Payment of acquisition and financing costs	-	(3,826)
Proceeds from issuance of long-term debt and other financing arrangements	-	11,916
Net amounts received on interest rate swap settlements	6,172	5,980
Restricted contributions received	4,041	5,376
NET CASH USED IN FINANCING ACTIVITIES	(25,997)	(19,322)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	20,529	(15,717)
CASH AND CASH EQUIVALENTS, beginning of year	59,185	74,902
CASH AND CASH EQUIVALENTS, end of year	\$ 79,714	\$ 59,185
SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:		
Cash paid for interest	\$ 38,982	\$ 40,546
Cash paid for federal and state income taxes	\$ 917	\$ 854
Construction related payables in accounts payable and accrued expenses	\$ 5,034	\$ 8,604
Assets contributed into joint venture	\$ 8,668	\$ -
Supplemental cash flow information regarding acquisitions:		
Assets acquired, net of cash	\$ -	\$ 12,715
Liabilities assumed	-	(8,459)
Acquisitions, net of cash acquired	\$ -	\$ 4,256

During the year ended June 30, 2014, the Alliance refinanced previously issued debt of \$318,385.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

NOTE A--ORGANIZATION AND OPERATIONS

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, Unicoi, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The primary operations of the Alliance consist of eleven acute and specialty care hospitals.

The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets attributable to the noncontrolling interests in the following subsidiaries:

- Smyth County Community Hospital and Subsidiary - the Alliance holds an 80% interest
- Norton Community Hospital and Subsidiaries - the Alliance holds a 50.1% interest
- Johnston Memorial Hospital, Inc. and Subsidiaries - the Alliance holds a 50.1% interest

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices, real estate and ambulatory surgery centers and provides other healthcare services to individuals in Tennessee and Virginia.

The Alliance is a 99.9% shareholder of Integrated Solutions Health Network, LLC, a for-profit entity that owns a for-profit insurance company and an accountable care organization and administers a provider-sponsored health care delivery network,

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc., a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance.

NOTE B--SIGNIFICANT ACCOUNTING POLICIES

Principles of Consolidation: The accompanying consolidated financial statements include the accounts of the Alliance and its consolidated subsidiaries after elimination of all significant intercompany accounts and transactions.

Use of Estimates: The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

Cash and Cash Equivalents: Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents.

Investments: Investments include trading securities and held-to-maturity securities. Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value utilizing observable and unobservable inputs. Investments which the Alliance has the positive intent and ability to hold to maturity are classified as held-to-maturity and are stated at amortized cost. Realized gains and losses are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Management evaluates whether unrealized losses on held-to-maturity investments indicate other-than-temporary impairment. Such evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2015.

Investments in joint ventures are reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value. Other assets include investments in joint ventures of \$5,180 and \$1,364 at June 30, 2015 and 2014, respectively. During 2015, the Alliance contributed assets into a joint venture which owns and operates a rehabilitation hospital.

Inventories: Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market with cost determined by first-in, first-out method.

Property, Plant and Equipment: Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of buildings and equipment held under capital leases is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2015 and 2014.

Other assets include property held for resale and expansion of \$19,316 and \$20,793, respectively, at June 30, 2015 and 2014. Property held for resale and expansion primarily represents land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2015 and 2014.

Goodwill: Goodwill is evaluated for impairment at least annually. The Alliance comprises a single reporting unit for evaluation of goodwill. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe the goodwill to be impaired as of June 30, 2015 and 2014. Management's estimates utilized in the evaluation contain significant estimates and it is reasonably possible that such estimates could change in the near term.

Deferred Financing, Acquisition Costs and Other Charges: Other assets include deferred financing, acquisition costs and other charges of \$24,755 and \$25,841 at June 30, 2015 and 2014, respectively. Deferred financing costs are amortized over the life of the respective bond issue using the average bonds outstanding method.

Derivative Financial Instruments: The Alliance is a party to various interest rate swaps. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payers.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payers emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. The primary uncertainty lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients. Additions to the allowance for uncollectible accounts result from the provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

For uninsured patients that do not qualify for charity care, the Alliance recognizes revenue on the basis of discounted rates under the Alliance's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has their bill reduced to the amount which generally would be billed to a commercially insured patient. The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care: The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue. Charges forgone, based on established rates, totaled \$85,988 and \$109,550 during 2015 and 2014, respectively. The estimated direct and indirect cost of providing these services totaled \$17,953 and \$24,011 in 2015 and 2014, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

Excess of Revenue, Gains and Support Over Expenses and Losses: The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption Excess of Revenue, Gains and Support Over Expenses and Losses (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, certain pension and related adjustments, and transactions with noncontrolling interests.

Income Taxes: The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. The Alliance's taxable subsidiaries are discussed in Note L. The Alliance has no significant uncertain tax positions at June 30, 2015 and 2014. At June 30, 2015, tax returns for 2011 through 2014 are subject to examination by the Internal Revenue Service.

Temporarily and Permanently Restricted Net Assets: Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Consolidated Statements of Operations and Changes in Net Assets as net assets released from restrictions. The Alliance's policy is to net contribution and grant revenues against related expenses and present such amounts as a part of other revenue, gains and support in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

Premium Revenue: Premium revenue include premiums from individuals and the Centers for Medicare & Medicaid Services (CMS). CMS premium revenue is based on predetermined prepaid rates under Medicare risk contracts. Premiums are recognized in the month in which the members are entitled to health care services. Premiums collected in advance are deferred and recorded as unearned premium revenue. Premium deficiency losses are recognized when it is probable that expected future claim expenses will exceed future premiums on existing contracts. Management evaluated the need for a premium deficiency reserve and recorded an estimated reserve of \$2,000 at June 30, 2015 and 2014.

Medicare Shared Savings Program (MSSP): The Alliance participates in CMS's Medicare Shared Savings Program which is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Accountable care organizations participating in the program are assigned beneficiaries by CMS and are entitled to share in the savings if they are able to lower growth in Medicare Parts A and B fee-for-service costs while meeting performance standards on quality of care. Utilizing statistical data and the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

methodology employed by CMS, management estimated and recognized \$2,857 and \$5,425 of shared savings in 2015 and 2014, respectively.

Electronic Health Record (EHR) Incentives: The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified EHR technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are recorded upon the Alliance's attainment of program and attestation criteria. The incentive payments are subject to regulatory audit. During the years ending June 30, 2015 and 2014, the Alliance recognized EHR incentive revenues of \$1,883 and \$18,269, respectively. EHR incentive revenues are included in other revenue, gains and support in the accompanying Consolidated Statements of Operations. The Alliance incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Alliance's receipt or recognition of the EHR incentive payments.

Medical Costs: The cost of health care services is recognized in the period in which services are provided. Medical costs include an estimate of the cost of services provided to members by third-party providers, which have been incurred but not reported.

Subsequent Events: The Alliance evaluated all events or transactions that occurred after June 30, 2015, through October 28, 2015, the date the consolidated financial statements were available to be issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2015 consolidated financial statements, other than as disclosed in Note P.

Reclassifications: Certain 2014 amounts have been reclassified to conform with the 2015 presentation in the accompanying consolidated financial statements.

New Accounting Pronouncements: In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. Under ASU 2014-09, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the accounting standard requires disclosure of the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2017. Management is currently evaluating the impact of adopting the accounting standard.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

NOTE C--INVESTMENTS

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	<u>2015</u>	<u>2014</u>
Designated or restricted:		
Under safekeeping agreements	\$ 8,221	\$ 8,220
By Board to satisfy regulatory requirements	1,529	6,759
Under bond indenture agreements:		
For debt service and interest payments	53,812	55,123
For capital acquisitions	8,507	16,127
	<u>72,069</u>	<u>86,229</u>
Less: amount required to meet current obligations	(19,598)	(25,029)
	<u>\$ 52,471</u>	<u>\$ 61,200</u>

Assets limited as to use consist of the following at June 30:

	<u>2015</u>	<u>2014</u>
Cash and cash equivalents	\$ 49,665	\$ 54,437
U.S. Government and agency securities	19,757	28,518
Corporate and foreign bonds	860	2,354
Municipal obligations	1,787	920
	<u>\$ 72,069</u>	<u>\$ 86,229</u>

Held-to-maturity securities (other than assets limited as to use) are carried at amortized cost and consist of the following at June 30:

	<u>2015</u>	<u>2014</u>
Cash and cash equivalents	\$ 2,781	\$ 220
Corporate and foreign bonds	30,967	35,131
Municipal obligations	5,765	3,408
	<u>\$ 39,513</u>	<u>\$ 38,759</u>

Held-to-maturity securities had gross unrealized gains and losses of \$98 and \$425, respectively, at June 30, 2015 and \$206 and \$456, respectively, at June 30 2014. At June 30, 2015, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$12,710

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

and \$359, respectively, which had been at an unrealized loss position for over one year. At June 30, 2014, the Alliance held securities within the held-to-maturity portfolio with a fair value and unrealized loss of \$13,513 and \$456, respectively, which had been at an unrealized loss position for over one year. At June 30, 2015, the contractual maturities of held-to-maturity securities were \$10,020 due in one year or less, \$16,580 due from one to five years and \$12,913 due after five years.

Trading securities consist of the following at June 30:

	<u>2015</u>	<u>2014</u>
Cash and cash equivalents	\$ 20,789	\$ 50,623
U.S. Government and agency securities	76,167	69,805
Corporate and foreign bonds	95,726	96,749
Municipal obligations	23,330	21,409
U.S. equity securities	5,419	1,868
Mutual funds	293,983	253,301
Alternative investments	87,144	54,761
	<u>\$ 602,558</u>	<u>\$ 548,516</u>

The net investment gain is comprised of the following for the years ending June 30:

	<u>2015</u>	<u>2014</u>
Interest and dividend income, net of fees	\$ 13,894	\$ 12,074
Net realized gains on the sale of securities	9,260	15,311
Change in net unrealized gains on securities	(6,138)	23,318
	<u>\$ 17,016</u>	<u>\$ 50,703</u>

The Alliance is a member of Premier Inc.'s (Premier) group purchasing organization and holds Class B Units which are convertible into cash or Class A common stock over a seven year vesting period. The Alliance records an investment relative to the estimated fair value of its Class B units, \$14,724 and \$14,713 at June 30, 2015 and 2014, respectively. In addition, as the vesting period is tangential to the Alliance's continued participation in the group purchasing contract, the Alliance recorded a liability equivalent to the estimated fair value of the Class B units, which is included within other long-term liabilities in the Consolidated Balance Sheets. The liability is being amortized as a vendor incentive over the vesting period. During 2015 and 2014, the Alliance recognized \$4,045 and \$2,933, respectively, related to the vendor incentive which is included within other revenue, gains and support in the Consolidated Statements of Operations.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

NOTE D--DERIVATIVE TRANSACTIONS

The Alliance is subject to an enforceable master netting arrangement in the form of an ISDA agreement with Bank of America, Merrill Lynch (BofAML). The ISDA agreement requires that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2015 and 2014, the Alliance was not required to post additional collateral. Under the terms of this agreement, offsetting of derivative contracts is permitted in the event of default of either party to the agreement.

The following is a summary of the interest rate swap agreements at June 30, 2015 and 2014:

<i>Notional Amount</i>	<i>Termination</i>	<i>Counterparty</i>	<i>Current Payments:</i>		<i>Estimated Fair Value</i>	
			<i>Receive</i>	<i>Pay</i>	<i>2015</i>	<i>2014</i>
\$170,000	4/2026	BofAML	1.14%	0.00%	\$ 5,205	\$ 3,089
\$95,000	4/2026	BofAML	1.14%	0.00%	2,929	1,748
\$173,030	4/2034	BofAML	1.16%	0.00%	884	(1,884)
\$82,055	7/2033	BofAML	67% USD-LIBOR- BBA	0.312% + USD-SIFMA	(8,253)	(9,365)
\$50,000	7/2038	BofAML	67% (USD-LIBOR- BBA + 0.15%)	USD-SIFMA	(3,351)	(4,210)
\$19,400	7/2018	BofAML	4.50%	1.05% + USD-SIFMA	48	63
\$4,293	7/2015	First Tennessee Bank	0.00%	USD-LIBOR- BBA	(3)	(44)
					\$ (2,541)	\$ (10,603)

The Alliance recognized net settlement income on the interest rate swap agreements of \$6,172 and \$5,980 in 2015 and 2014, respectively.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

NOTE E--PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of the following at June 30:

	<u>2015</u>	<u>2014</u>
Land	\$ 60,337	\$ 60,722
Buildings and leasehold improvements	766,089	760,853
Property and improvements held for leasing	83,582	80,824
Equipment and information technology infrastructure	733,315	700,748
Buildings and equipment held under capital lease	249	340
	<u>1,643,572</u>	<u>1,603,487</u>
Less: Allowances for depreciation and amortization	<u>(815,105)</u>	<u>(757,641)</u>
	828,467	845,846
Construction in progress	18,622	35,583
	<u>\$ 847,089</u>	<u>\$ 881,429</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$29,520 and \$27,500 at June 30, 2015 and 2014, respectively. Net interest capitalized was \$925 and \$1,533 for the years ended June 30, 2015 and 2014, respectively.

NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

<i>Description</i>	<i>Rate as of June 30, 2015</i>	<i>Outstanding Balance</i>	
		<i>2015</i>	<i>2014</i>
2013 Hospital Revenue and Refunding Revenue Bonds:			
\$61,180 variable rate tax-exempt term bond, due August 2031	1.15%	\$ 327,785	\$ 328,665
\$47,970 variable rate tax-exempt term bond, due August 2032	0.93%		
\$13,350 variable rate tax-exempt term bond, due August 2038	1.15%		
\$89,370 variable rate tax-exempt term bonds, due August 2042	1.12% - 1.23%		
\$16,235 variable rate tax-exempt term bond, due August 2043	0.07%		
\$99,680 variable rate taxable term bond due August 2043	0.12%		
2012 Hospital Revenue Bonds:			
(net of unamortized premium of \$1,696 and \$1,756 at June 30, 2015 and 2014, respectively)			
\$55,000 fixed rate tax-exempt term bond, due August 2042	5.00%	56,696	56,756
2011 Hospital Revenue and Refunding and Improvement Bonds:			
\$74,795 variable rate tax-exempt term bonds, due July 2033	0.08%	94,320	104,710
\$19,525 variable rate tax-exempt term bond, due July 2033	1.11%		

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

<i>Description</i>	<i>Rate as of June 30, 2015</i>	<i>Outstanding Balance</i>	
		<i>2015</i>	<i>2014</i>
2010 Hospital Revenue Refunding Bonds:			
(net of unamortized premium of \$1,441 and \$1,523 at June 30, 2015 and 2014, respectively)			
\$33,960 fixed rate tax-exempt serial bonds, through 2020	4.00% to 5.00%	173,271	180,993
\$4,355 fixed rate tax-exempt term bond, due July 2023	5.00%		
\$14,985 fixed rate tax-exempt term bond, due July 2025	5.38%		
\$4,250 fixed rate tax-exempt term bond, due July 2028	5.50%		
\$19,230 fixed rate tax-exempt term bond, due July 2030	5.63%		
\$95,050 fixed rate tax-exempt term bonds, due July 2038	6.00% - 6.50%		
2009 Hospital Revenue Bonds:			
(net of unamortized discount of \$2,176 and \$2,267 at June 30, 2015 and 2014, respectively)			
\$14,425 fixed rate tax-exempt term bonds, due July 2019	7.25%	117,264	119,813
\$21,730 fixed rate tax-exempt term bonds, due July 2029	7.50%		
\$83,285 fixed rate tax-exempt term bonds, due July 2038	7.75% - 8.00%		
2007B Taxable Hospital Revenue Bonds:			
\$15,920 variable rate taxable term bond due July 2019	0.12%	15,920	19,515
2006 Hospital First Mortgage Revenue Bonds:			
(net of unamortized premium of \$123 and \$129 at June 30, 2015 and 2014, respectively)			
\$3,965 fixed rate tax-exempt serial bonds, through 2019	5.00%	167,143	167,864
\$7,375 fixed rate tax-exempt term bond, due July 2026	5.25%		
\$20,505 fixed rate tax-exempt term bond, due July 2031	5.50%		
\$135,175 fixed rate tax-exempt term bond, due July 2036	5.50%		
2001 Hospital First Mortgage Revenue Bond:			
\$19,400 fixed rate tax-exempt term bond, due July 2026	4.50%	19,400	20,400
2000 Hospital First Mortgage Revenue and Refunding Bonds:			
\$42,000 fixed rate tax-exempt term bond, due July 2026	8.50%	81,538	81,006
\$39,538 fixed rate tax-exempt Capital Appreciation Bond, interest and principal due July 2026 through 2030	6.63%		
Capitalized lease obligations secured by equipment			
Various monthly principal and interest payments through December 2016	Various	350	806
Notes payable secured by real estate			
Paid-off in 2015	Various	-	5,542
Promissory notes secured by assets of certain subsidiaries			
Various monthly principal and interest payments through 2019	Various	1,705	1,944
Term note			
Monthly principal payments of \$60 plus variable rate interest beginning November 2012 through September 2015; remaining principal due October 2015	1.17%	16,160	16,883
Notes payable secured by equipment			
Various monthly principal and interest payments through 2016	Various	395	790
		1,071,947	1,105,687
Less current portion		(40,286)	(30,618)
		<u>\$ 1,031,661</u>	<u>\$ 1,075,069</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

Capital Appreciation Bonds: The Series 2000 Bonds include \$14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is \$93,675.

Other: Outstanding tax-exempt bond obligations that were insured under municipal bond insurance policies were \$81,538 and \$81,006 at June 30, 2015 and 2014, respectively. Under terms of these policies, the insurer guarantees the Alliance's payment of principal and interest. At June 30, 2015 and 2014, the Alliance held \$206,630 and \$212,360, respectively, in variable rate demand bonds with letter of credit support and \$231,395 and \$240,530, respectively, in variable rate bonds held under direct purchase agreements.

Early Redemption: Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

Derecognized Bonds: In previous years, the Alliance advance refunded debt by placing required funds in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments of the outstanding debt. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2015 due to previous advance refundings totaled \$185,470.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of \$54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

Financing Arrangements: The Alliance granted a deed of trust on Johnson City Medical Center and Sycamore Shoals Hospital to secure the payment of the outstanding bond indebtedness. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The Johnston Memorial Hospital, Inc. and Subsidiaries (JMH) Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

Certain members of the Alliance and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property. These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance and JMH are in compliance with all such covenants at June 30, 2015.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2015 are as follows:

<u>Year Ending June 30,</u>	
2016	\$ 40,286
2017	24,112
2018	24,793
2019	25,926
2020	27,048
Thereafter	<u>928,699</u>
	1,070,864
Net premium	<u>1,083</u>
	<u>\$ 1,071,947</u>

NOTE G--SELF-INSURANCE PROGRAMS

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a \$25,000 umbrella liability policy that attaches over the self-insurance limits of \$10,000 per claim and a \$15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of \$1,000 per occurrence. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

At June 30, 2015, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2015 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2015 and 2014 was \$12,616 and \$13,220, respectively. The discount rate utilized was 5% at June 30, 2015 and 2014.

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

NOTE H--NET PATIENT SERVICE REVENUE

Patient service revenue, net of contractual allowances and discounts, is composed of the following for the years ended June 30:

	<u>2015</u>		<u>2014</u>
Third-party payers	\$ 965,865	\$	933,491
Patients	151,089		113,276
Patient service revenue	<u>\$ 1,116,954</u>	\$	<u>1,046,767</u>

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

The Alliance also provides services to uninsured and underinsured patients that do not qualify for financial assistance. Based on historical experience, a significant portion of uninsured and underinsured patients are unable or unwilling to pay the portion of their bill for which they are financially responsible, and a significant provision for bad debts is recorded in the period the services are provided.

The Alliance's allowance for doubtful accounts totaled \$73,805 and \$47,853 at June 30, 2015 and 2014, respectively. The allowance for doubtful accounts increased from 23% of patient accounts receivable, net of contractual allowances in 2014 to 31% of patient accounts receivable, net of contractual allowances in 2015. The increase is mainly related to the growing popularity of high-deductible insurance plans resulting in higher deductibles and out-of-pocket costs for patients. Management's estimate of the allowance for doubtful accounts is an estimate subject to change in the

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

near term. The provision for bad debts associated with the Alliance's ancillary service lines are not significant.

NOTE I--THIRD-PARTY REIMBURSEMENT

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare and various other commercial payers. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee and Medicaid. These payments recognized totaled \$10,386 and \$10,860 for the years ended June 30, 2015 and 2014, respectively.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are transitioning from cost-based reimbursement principles to a prospective payment system. Full implementation of this transition is expected to take place over multiple years.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by \$3,076 and \$6,201 in 2015 and 2014, respectively.

Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts, if any. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2016, although the amount of any change cannot be estimated.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2015.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

NOTE J--EMPLOYEE BENEFIT PLANS

The Alliance sponsors a defined contribution retirement plan (the Plan) which covers substantially all employees. The Alliance makes contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2015 and 2014 was \$15,601 and \$13,850, respectively.

NCH maintains a frozen defined benefit pension plan and a frozen post-retirement employee benefit plan. The accrued unfunded pension liability was \$1,806 and \$2,086, and the accrued unfunded post-retirement liability was \$6,307 and \$5,857 at June 30, 2015 and 2014, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement dates, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,727 and \$511 to the plan during 2015 and 2014, respectively. Other assets at June 30, 2015 and 2014 include \$13,030 and \$11,302, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. Contributions to the Section 457(f) plan during 2015 and 2014 were not significant.

NOTE K--CONCENTRATION OF RISK

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia, a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

Years Ended June 30, 2015 and 2014

residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee acute-care operations was approximately 52% of total net patient service revenue in 2015 and 2014.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30. The patient responsibility related to charges for which the third-party has not yet paid is included within the third-party payer categories.

	<u>2015</u>	<u>2014</u>
Medicare	41%	39%
TennCare/Medicaid	15%	18%
Commercial	26%	28%
Other third-party payers	8%	8%
Patients	10%	7%
	<u>100%</u>	<u>100%</u>

Approximately 91% and 88% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2015 and 2014, respectively. Admitting physicians are primarily practitioners in the regional area.

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Alliance may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

NOTE L--INCOME TAXES

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2015 and 2014, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$30,700 and \$27,085, respectively, related to operating loss carryforwards, which expire through 2033. At June 30, 2015 and 2014, BRMM had state net operating loss carryforwards of \$75,619 and \$74,191, respectively, which expire through 2029. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

NOTE M--OTHER COMMITMENTS AND CONTINGENCIES

Construction in Progress: Construction in progress at June 30, 2015 represents costs incurred related to various hospital and medical office building facility renovations and additions and information technology infrastructure. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be \$30,508 at June 30, 2015. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

Employee Scholarships: The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degrees. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately, and interest is charged until the funds are repaid. Other receivables at June 30, 2015 and 2014 include \$7,095 and \$8,685, respectively, related to students in school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program, net of an estimated allowance.

Operating Leases and Maintenance Contracts: Total lease expense for the years ended June 30, 2015 and 2014 was \$7,414 and \$7,901, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

<u>Year Ending June 30,</u>		
2016	\$	7,346
2017		4,614
2018		3,605
2019		3,279
2020		2,481
Thereafter		11,240
	\$	<u>32,565</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

NOTE N--FAIR VALUE MEASUREMENT

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2015 and 2014, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

Held-to-Maturity Securities: The estimated fair value of the Alliance's held-to-maturity securities at June 30, 2015 and 2014, is \$39,186 and \$38,508, respectively, and would be classified in level 2 of the fair value hierarchy (described below). The fair value is based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations.

Investment in Joint Ventures: It is not practical to estimate the fair market value of the investments in joint ventures.

Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities: Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities.

Long-Term Debt: The estimated fair value of the Alliance's long-term debt at June 30, 2015 and 2014, is \$1,130,580 and \$1,172,357, respectively, and would be classified in Level 2 in the fair value hierarchy. The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

FASB Accounting Standards Codification 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.
- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

- be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.
- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

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

The following table sets forth, by level within the fair value hierarchy, the financial instruments measured at fair value as of June 30, 2015 and 2014:

	<i>Total</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
June 30, 2015				
Cash and cash equivalents	\$ 70,439	\$ 70,439	\$ -	\$ -
U.S. Government and agency securities	88,083	88,083	-	-
Corporate and foreign bonds	96,586	-	96,586	-
Municipal obligations	23,329	-	23,329	-
U.S. equity securities	5,419	5,419	-	-
Mutual funds	293,983	212,323	81,660	-
Alternative investments	87,144	-	72,420	14,724
Total assets	<u>\$ 664,983</u>	<u>\$ 376,264</u>	<u>\$ 273,995</u>	<u>\$ 14,724</u>
Derivative agreements	<u>\$ (2,541)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (2,541)</u>
June 30, 2014				
Cash and cash equivalents	\$ 98,956	\$ 98,956	\$ -	\$ -
U.S. Government and agency securities	90,474	90,474	-	-
Corporate and foreign bonds	99,103	-	99,103	-
Municipal obligations	21,409	-	21,409	-
U.S. equity securities	1,868	1,868	-	-
Mutual funds	253,301	177,067	76,234	-
Alternative investments	69,474	-	54,761	14,713
Total assets	<u>\$ 634,585</u>	<u>\$ 368,365</u>	<u>\$ 251,507</u>	<u>\$ 14,713</u>
Derivative agreements	<u>\$ (10,603)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ (10,603)</u>

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued *(Dollars in Thousands)*

Years Ended June 30, 2015 and 2014

Fair values for the Alliance's fixed maturity securities are based on prices provided by the Alliance's investment managers and its custodian bank, which use a variety of pricing sources to determine market valuations. Fair values of equity securities have been determined by the Alliance from market quotations.

Alternative Investments: The Alliance generally uses net asset value per unit as provided by external investment managers without further adjustment as the practical expedient estimate of the fair value of its alternative investment in a real estate fund. Accordingly, such values may differ from values that would have been used had an active market for the investments existed. The real estate fund invests primarily in U.S. commercial real estate. The Alliance may request redemption of all or a portion of its interests as of the end of a calendar quarter by delivering written notice to the fund managers at least 60 days prior to the end of the quarter. Such redemptions are subject to the capital requirements of the fund manager.

The Alliance's investment in Premier Class B units does not have a readily determinable fair value and have been reported at estimated fair market value. The significant unobservable inputs primarily relate to management's estimate of the discount for lack of marketability of 12%. Accordingly, such value may differ from values that would have been used had an active market for the investment existed and as such it has been classified in Level 3 of the fair value hierarchy.

Derivative Agreements: The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses certain observable market-based inputs. The fair values of interest rate agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2015 and 2014 resulted in a decrease in the fair value of the related liability of \$713 and \$4,584, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued
(Dollars in Thousands)

Years Ended June 30, 2015 and 2014

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2015 and 2014:

	<i>Alternative Investment</i>	<i>Derivatives, Net</i>
July 1, 2013	\$ -	\$ (8,185)
Total unrealized/realized losses	-	(2,761)
Net investment income	-	343
Additions	14,713	-
June 30, 2014	14,713	(10,603)
Total unrealized/realized gains	6,978	7,718
Net investment income	-	344
Settlements	(6,967)	-
June 30, 2015	<u>\$ 14,724</u>	<u>\$ (2,541)</u>

NOTE O--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION

The Alliance does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Alliance receives substantially all of its resources from providing healthcare services in a manner similar to business enterprises, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

NOTE P--SUBSEQUENT EVENTS

The Alliance and Wellmont Health System (Wellmont) have agreed to exclusively explore the creation of a new, integrated and locally governed health system. Wellmont operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont and the Alliance have filed a letter of intent (LOI) with the Tennessee Department of Health, indicating the organizations will submit an application for a Certificate of Public Advantage (COPA). The two organizations have submitted a similar letter of intent with the Southwest Virginia Health Authority, signaling their intent to request approval by the commonwealth of the anticipated cooperative agreement between the two systems. A COPA in Tennessee and the cooperative agreement approval process in Virginia will allow Wellmont and the Alliance to merge, with the states actively supervising the proposed new health system to ensure it complies with the provisions of the COPA intended to contain costs and sustain high quality, affordable care. The two organizations are in the process of finalizing a definitive agreement. The date for expected completion of the merger has not been set but will not occur before state approval has been granted.

Supplemental Information

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Balance Sheets
(Smyth County Community Hospital and Subsidiary and
Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)*

June 30, 2015

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	\$ 2,940	\$ 6,798
Patient accounts receivable, less estimated allowances for uncollectible accounts	6,295	11,137
Other receivables, net	156	310
Inventories and prepaid expenses	1,079	2,061
Estimated amounts due from third-party payers, net	793	292
TOTAL CURRENT ASSETS	11,263	20,598
INVESTMENTS, less amounts required to meet current obligations	24,807	30,451
PROPERTY, PLANT AND EQUIPMENT, net	67,550	50,275
OTHER ASSETS		
Net deferred financing, acquisition costs and other charges	139	210
Other assets	741	-
TOTAL OTHER ASSETS	880	210
	\$ 104,500	\$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Balance Sheets - Continued
(Smyth County Community Hospital and Subsidiary and
Norton Community Hospital and Subsidiaries)
(Dollars in Thousands)

June 30, 2015

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accrued interest payable	\$ 12	\$ 15
Current portion of long-term debt and capital lease obligations	134	110
Accounts payable and accrued expenses	2,323	6,245
Accrued salaries, compensated absences and amounts withheld	2,116	4,388
Payables to affiliates, net	342	89
TOTAL CURRENT LIABILITIES	4,927	10,847
OTHER LIABILITIES		
Long-term debt and capital lease obligations, less current portion	15,830	20,985
Estimated professional liability self-insurance	442	632
Other long-term liabilities	1,178	8,200
TOTAL LIABILITIES	22,377	40,664
NET ASSETS		
Unrestricted net assets	82,114	60,734
Temporarily restricted net assets	9	136
TOTAL NET ASSETS	82,123	60,870
	\$ 104,500	\$ 101,534

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Statements of Operations and Changes in Net Assets
(Smyth County Community Hospital and Subsidiary and Norton
Community Hospital and Subsidiaries)
(Dollars in Thousands)*

Year Ended June 30, 2015

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
UNRESTRICTED NET ASSETS:		
Revenue, gains and support:		
Patient service revenue, net of contractual allowances and discounts	\$ 48,370	\$ 78,667
Provision for bad debts	(5,332)	(8,546)
Net patient service revenue	43,038	70,121
Net investment gain	651	746
Other revenue, gains and support	1,745	2,576
TOTAL REVENUE, GAINS AND SUPPORT	45,434	73,443
Expenses and losses:		
Salaries and wages	17,289	23,681
Physician salaries and wages	257	6,043
Contract labor	170	567
Employee benefits	4,365	8,965
Fees	9,050	8,326
Supplies	5,349	8,793
Utilities	978	1,286
Other	4,348	7,753
Depreciation	4,289	4,489
Amortization	8	30
Interest and taxes	156	257
TOTAL EXPENSES AND LOSSES	46,259	70,190
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(825)	3,253
Pension and postretirement liability adjustments	-	(305)
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	(825)	2,948

MOUNTAIN STATES HEALTH ALLIANCE

*Consolidated Statements of Operations and Changes in Net Assets - Continued
(Smyth County Community Hospital and Subsidiary and Norton
Community Hospital and Subsidiaries)
(Dollars in Thousands)*

Year Ended June 30, 2015

	<i>Smyth County Community Hospital and Subsidiary</i>	<i>Norton Community Hospital and Subsidiaries</i>
TEMPORARILY RESTRICTED NET ASSETS:		
Restricted grants and contributions	8	134
Net assets released from restrictions	(8)	(160)
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	-	(26)
INCREASE (DECREASE) IN TOTAL NET ASSETS	(825)	2,922
NET ASSETS, BEGINNING OF YEAR	82,948	57,948
NET ASSETS, END OF YEAR	<u>\$ 82,123</u>	<u>\$ 60,870</u>

MOUNTAIN STATES HEALTH ALLIANCE

***Consolidating Balance Sheet
(Obligated Group and Other Entities)
(Dollars in Thousands)***

June 30, 2015

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
ASSETS				
CURRENT ASSETS				
Cash and cash equivalents	\$ 47,025	\$ 32,689	\$ -	\$ 79,714
Current portion of investments	19,598	-	-	19,598
Patient accounts receivable, less estimated allowance for uncollectible accounts	134,777	27,479	-	162,256
Other receivables, net	17,873	15,413	-	33,286
Inventories and prepaid expenses	25,427	8,542	-	33,969
TOTAL CURRENT ASSETS	244,700	84,123	-	328,823
INVESTMENTS, less amounts required to meet current obligations	458,373	236,169	-	694,542
EQUITY IN AFFILIATES	351,724	-	(351,724)	-
PROPERTY, PLANT AND EQUIPMENT, net	614,870	232,219	-	847,089
OTHER ASSETS				
Goodwill	152,600	3,996	-	156,596
Net deferred financing, acquisition costs and other charges	23,504	1,251	-	24,755
Other assets	44,738	8,302	-	53,040
TOTAL OTHER ASSETS	220,842	13,549	-	234,391
	\$ 1,890,509	\$ 566,060	\$ (351,724)	\$ 2,104,845

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Balance Sheet – Continued
(Obligated Group and Other Entities)
(Dollars in Thousands)

June 30, 2015

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
LIABILITIES AND NET ASSETS				
CURRENT LIABILITIES				
Accrued interest payable	\$ 18,125	\$ 34	\$ -	\$ 18,159
Current portion of long-term debt and capital lease obligations	22,040	18,246	-	40,286
Accounts payable and accrued expenses	80,408	19,893	-	100,301
Accrued salaries, compensated absences and amounts withheld	54,519	17,547	-	72,066
Payables to (receivables from) affiliates, net	15,314	(15,314)	-	-
Estimated amounts due to third-party payers, net	3,909	872	-	4,781
TOTAL CURRENT LIABILITIES	194,315	41,278	-	235,593
OTHER LIABILITIES				
Long-term debt and capital lease obligations, less current portion	1,012,167	19,494	-	1,031,661
Estimated fair value of derivatives, net	2,541	-	-	2,541
Estimated professional liability self-insurance	7,362	1,099	-	8,461
Other long-term liabilities	35,176	3,507	-	38,683
TOTAL LIABILITIES	1,251,561	65,378	-	1,316,939
NET ASSETS				
Unrestricted net assets				
Mountain States Health Alliance	583,287	344,360	(344,360)	583,287
Noncontrolling interests in subsidiaries	42,160	143,222	5,736	191,118
TOTAL UNRESTRICTED NET ASSETS	625,447	487,582	(338,624)	774,405
Temporarily restricted net assets				
Mountain States Health Alliance	13,303	12,966	(12,966)	13,303
Noncontrolling interests in subsidiaries	71	7	(7)	71
TOTAL TEMPORARILY RESTRICTED NET ASSETS	13,374	12,973	(12,973)	13,374
Permanently restricted net assets				
	127	127	(127)	127
TOTAL NET ASSETS	638,948	500,682	(351,724)	787,906
	\$ 1,890,509	\$ 566,060	\$ (351,724)	\$ 2,104,845

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Operations (Obligated Group and Other Entities) (Dollars in Thousands)

Year Ended June 30, 2015

	<i>Obligated Group</i>	<i>Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
Revenue, gains and support:				
Patient service revenue, net of contractual allowances and discounts	\$ 925,979	\$ 203,883	\$ (12,908)	\$ 1,116,954
Provision for bad debts	(104,724)	(22,795)	-	(127,519)
Net patient service revenue	821,255	181,088	(12,908)	989,435
Premium revenue	-	32,184	-	32,184
Net investment gain	12,486	4,530	-	17,016
Net derivative gain	13,195	695	-	13,890
Other revenue, gains and support	27,244	97,465	(88,138)	36,571
Equity in net gain of affiliates	716	10,275	(10,991)	-
TOTAL REVENUE, GAINS AND SUPPORT	874,896	326,237	(112,037)	1,089,096
Expenses:				
Salaries and wages	284,643	67,093	(6,581)	345,155
Physician salaries and wages	64,838	71,222	(55,781)	80,279
Contract labor	3,101	2,913	(598)	5,416
Employee benefits	66,881	17,443	(7,018)	77,306
Fees	97,754	35,093	(12,156)	120,691
Supplies	146,516	29,660	(126)	176,050
Utilities	12,981	3,798	(4)	16,775
Medical Costs	-	30,566	(12,183)	18,383
Other	61,323	26,524	(6,370)	81,477
Depreciation	51,307	15,903	-	67,210
Amortization	1,488	69	-	1,557
Interest and taxes	41,599	2,098	-	43,697
TOTAL EXPENSES	832,431	302,382	(100,817)	1,033,996
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 42,465	\$ 23,855	\$ (11,220)	\$ 55,100

MOUNTAIN STATES HEALTH ALLIANCE

Consolidating Statement of Changes in Net Assets (Obligated Group and Other Entities) (Dollars in Thousands)

Year Ended June 30, 2015

	<i>Obligated Group</i>		<i>Total Obligated Group</i>	<i>Other Entities</i>		<i>Total Other Entities</i>	<i>Eliminations</i>	<i>Total</i>
	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>		<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>			
UNRESTRICTED NET ASSETS:								
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 41,008	\$ 1,457	\$ 42,465	\$ 13,832	\$ 10,023	\$ 23,855	\$ (11,220)	\$ 55,100
Pension and other defined benefit plan adjustments	(178)	(152)	(330)	(207)	(206)	(413)	413	(330)
Net assets released from restrictions used for the purchase of property, plant and equipment	478	-	478	478	-	478	(478)	478
Repurchases of noncontrolling interests, net	-	(1,000)	(1,000)	-	(14)	(14)	-	(1,014)
Distributions to noncontrolling interests	-	-	-	(458)	(355)	(813)	458	(355)
Net asset transfers	-	-	-	912	2,372	3,284	(3,284)	-
INCREASE IN UNRESTRICTED NET ASSETS	41,308	305	41,613	14,557	11,820	26,377	(14,111)	53,879
TEMPORARILY RESTRICTED NET ASSETS:								
Restricted grants and contributions	3,663	69	3,732	3,172	7	3,179	(3,179)	3,732
Net assets released from restrictions	(2,564)	(82)	(2,646)	(2,093)	(5)	(2,098)	2,098	(2,646)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	1,099	(13)	1,086	1,079	2	1,081	(1,081)	1,086
INCREASE IN TOTAL NET ASSETS	42,407	292	42,699	15,636	11,822	27,458	(15,192)	54,965
NET ASSETS, BEGINNING OF YEAR	554,310	41,939	596,249	341,817	131,407	473,224	(336,532)	732,941
NET ASSETS, END OF YEAR	\$ 596,717	\$ 42,231	\$ 638,948	\$ 357,453	\$ 143,229	\$ 500,682	\$ (351,724)	\$ 787,906

See note to supplemental information.

MOUNTAIN STATES HEALTH ALLIANCE

Note to Supplemental Information

Year Ended June 30, 2015

NOTE A--OBLIGATED GROUP MEMBERS

As described in Note F to the consolidated financial statements, the Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding bonds. The bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The members pledged pursuant to the Amended and Restated Master Trust Indenture between Mountain States Health Alliance and the Bank of New York Mellon Trust Company, NA as Master Trustee include Johnson City Medical Center Hospital, Indian Path Medical Center, Franklin Woods Community Hospital, Sycamore Shoals Hospital, Johnson County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Norton Community Hospital (hospital only), Smyth County Community Hospital (hospital only) and Blue Ridge Medical Management Corporation (parent company only), collectively defined as the Obligated Group (Obligated Group).

The supplemental consolidating information includes the accounts of the members of the Obligated Group after elimination of all significant intergroup accounts and transactions. Certain other subsidiaries of the Alliance are not pledged to secure the payment of the outstanding bonds as they are not part of the Obligated Group. These affiliates have been accounted for within the Obligated Group based upon the Alliance's original and subsequent investments, as adjusted for the Alliance's pro rata share of income or losses and any distributions, and are included as a part of equity in affiliates in the supplemental consolidating balance sheet.

Exhibit 24

Mountain State's current Fitch Ratings Watch

FITCH MAINTAINS RATING WATCH EVOLVING ON MOUNTAIN STATES HEALTH ALLIANCE (TN) REV BONDS

Fitch Ratings-New York-28 March 2016: Fitch Ratings maintains the Rating Watch Evolving on Mountain States Health Alliance's (MSHA) outstanding debt. A full list of outstanding debt follows at the end of this release.

SECURITY

Bonds are secured by pledged assets and a mortgage on Johnson City Medical Center and Sycamore Shoals Hospital. There is a debt service reserve fund on certain series of debt.

KEY RATING DRIVERS

MERGER PROCEEDING: In April 2015, Fitch placed MSHA's 'BBB+' rating on Rating Watch Evolving in response to the announcement that MSHA and Wellmont Health System (WHS; rated BBB+; Rating Watch Evolving) had signed an agreement to explore a merger. The maintenance of the Rating Watch Evolving reflects the continuation of the merger process.

COPA SUBMITTED: The two organizations have jointly submitted Certificate of Public Advantage (COPA) applications to Tennessee and Virginia. The COPA applications are the official request to each of these states for the approval of the merger. A public comment and consideration process is currently underway, which will last for 120 days in Tennessee and 150 days in Virginia. The timelines for the public comment periods officially start with the applications being declared complete by the states, which has yet to happen.

OPERATIONS REMAIN STEADY: MSHA had a 2.3% operating margin in FY2015 (June 30 year end) and 2.4x debt service coverage; results for the six month Dec. 31, 2015 interim period are consistent with the year end results.

RATING SENSITIVITIES

COMPLETION OF PENDING TRANSACTION: Resolution of the Rating Watch will be tied to the completion of the merger process and the treatment of the debt of Mountain States Health Alliance post-transaction.

CREDIT PROFILE

Headquartered in Johnson City, Tennessee, MSHA was formed in 1998 from the acquisition of six hospitals in Tennessee from Columbia/HCA and has grown into a large regional health care system with 13 hospitals (1,699 licensed beds) and other related entities, primarily serving northeast Tennessee and southwest Virginia. MSHA has a membership interest (ranging from 50.1% - 80%) in three of the hospitals in the system (Smyth County Community Hospital, Norton Community Hospital, Johnston Memorial Hospital). In fiscal 2015 (June 30 year end), MSHA had total operating revenue of \$1 billion.

Outstanding Debt:

--\$55,000,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital revenue bonds (Mountain States Health Alliance), series 2012A;

--\$5,250,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital revenue bonds, series 2009A;
--\$166,300,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2006A;
--\$18,300,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2001A;
--\$34,645,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue refunding bonds, series 2000A;
--\$27,840,000 Health and Educational Facilities Board of the City of Johnson City, Tennessee hospital first mortgage revenue bonds, series 2000C;
--\$5,245,000 Industrial Development Authority of Smyth County hospital revenue bonds, series 2009B;
--\$106,205,000 Industrial Development Authority of Washington County Virginia, hospital revenue bonds, series 2009C;
--\$11,995,000 Mountain States Health Alliance taxable note, series 2000D.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria

Revenue-Supported Rating Criteria (pub. 16 Jun 2014)

https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=750012

U.S. Nonprofit Hospitals and Health Systems Rating Criteria (pub. 09 Jun 2015)

https://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=866807

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Exhibit 25

FTI Consulting Report

To be submitted pursuant to CID.

Exhibit 26

Organizational Chart

Structure of Proposed Transaction

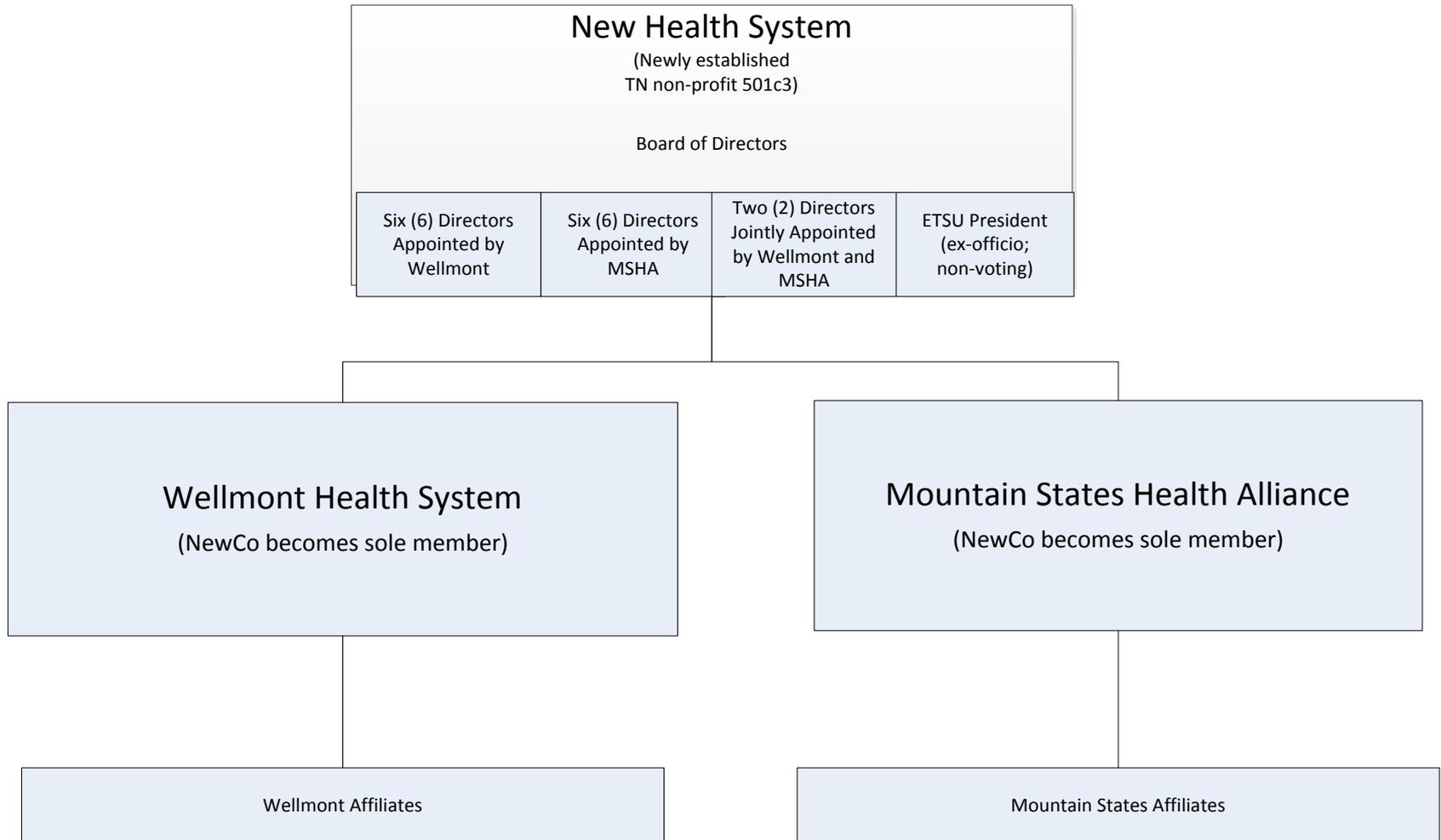


Exhibit 27

Mountain States' Q3 FY2016 Financials and Maximum Annual Debt Service Coverage Ratio



**Fiscal Year 2016
Third Quarter ending March 31, 2016**

Quarterly Financial Information
&
Historical Maximum Annual Debt Service Coverage Ratio

Consolidated & Unaudited

Mountain States Health Alliance
Comparative Balance Sheet

	March 31 2016	June 30 2015
<u>ASSETS</u>		
<u>CURRENT ASSETS</u>		
Cash and Cash Equivalents	72,030,451	79,713,574
Current Portion AWUIL	4,926,561	19,597,595
Accounts Receivable (Net)	167,367,087	162,255,802
Other Receivables	24,622,400	33,285,941
Due From Affiliates	527	(0)
Due From Third Party Payors	(0)	(0)
Inventories	28,889,682	26,646,561
Prepaid Expense	9,807,550	7,322,824
	<u>307,644,257</u>	<u>328,822,296</u>
 <u>ASSETS WHOSE USE IS LIMITED</u>	 <u>40,413,113</u>	 <u>52,470,955</u>
 <u>OTHER INVESTMENTS</u>	 <u>635,182,396</u>	 <u>642,070,837</u>
 <u>PROPERTY, PLANT AND EQUIPMENT</u>		
Land, Buildings and Equipment	1,700,664,673	1,662,193,378
Less Allowances for Depreciation	864,005,602	815,104,790
	<u>836,659,071</u>	<u>847,088,588</u>
 <u>OTHER ASSETS</u>		
Pledges Receivable	2,696,746	3,260,254
Long Term Compensation Investment	25,476,423	25,284,264
Investments in Unconsolidated Subsidiaries	7,633,537	5,179,805
Land / Equipment Held for Resale	4,631,959	4,631,959
Assets Held for Expansion	16,050,303	14,684,441
Investments in Subsidiaries	0	0
Goodwill	156,577,573	156,596,125
Deferred Charges and Other	23,799,887	24,754,992
	<u>236,866,427</u>	<u>234,391,841</u>
 <u>TOTAL ASSETS</u>	 <u>2,056,765,266</u>	 <u>2,104,844,518</u>
 <u>LIABILITIES AND NET ASSETS</u>		
<u>CURRENT LIABILITIES</u>		
Accounts Payable and Accrued Expense	85,981,790	92,133,309
Accrued Salaries, Benefits, and PTO	58,380,188	72,064,537
Claims Payable	9,262,484	8,167,693
Accrued Interest	9,221,428	18,159,055
Due to Affiliates	(0)	22
Due to Third Party Payors	9,392,866	4,781,320
Current Portion of Long Term Debt	24,223,026	40,286,349
	<u>196,461,781</u>	<u>235,592,285</u>
 <u>OTHER NON CURRENT LIABILITIES</u>		
Long Term Compensation Payable	12,405,257	12,250,293
Long Term Debt	1,010,013,749	1,031,660,759
Estimated Fair Value of Interest Rate Swaps	2,406,251	2,540,682
Deferred Income	27,222,996	15,259,244
Professional Liability Self-Insurance and Other	20,701,865	19,635,356
	<u>1,072,750,119</u>	<u>1,081,346,335</u>
 <u>TOTAL LIABILITIES</u>	 <u>1,269,211,900</u>	 <u>1,316,938,620</u>
 <u>NET ASSETS</u>		
Restricted Net Assets	13,959,809	13,502,164
Unrestricted Net Assets	575,587,131	583,215,057
Noncontrolling Interests in Subsidiaries	198,006,425	191,188,677
	<u>787,553,366</u>	<u>787,905,897</u>
 <u>TOTAL LIABILITIES AND NET ASSETS</u>	 <u>2,056,765,266</u>	 <u>2,104,844,518</u>

Mountain States Health Alliance
Statement of Revenue and Expense
As of March 31, 2016 and March 31, 2015

	FY16 Q3	FY15 Q3	FY16 YTD	FY15 YTD
<u>Revenue, Gains and Support</u>				
Patient service revenue, net of contractual allowances and discounts	287,153,198	292,064,611	873,720,869	840,390,491
Provision for bad debts	(34,267,588)	(41,498,739)	(105,013,659)	(100,375,420)
Net patient service revenue	252,885,610	250,565,872	768,707,210	740,015,071
Other operating revenue	8,279,397	9,054,733	26,266,620	26,926,979
TOTAL REVENUE, GAINS AND SUPPORT	261,165,007	259,620,605	794,973,830	766,942,050
<u>Expenses:</u>				
Salaries and wages	88,789,529	85,302,622	266,531,590	252,527,296
Physician salaries and wages	21,260,390	17,673,074	62,244,324	56,840,825
Contract Labor	1,449,654	1,453,093	4,777,566	4,252,570
Employee Benefits	19,200,042	20,296,987	56,516,782	54,797,671
Fees	30,714,896	28,814,408	94,424,150	85,093,729
Supplies	44,744,925	44,489,808	135,099,445	131,846,120
Utilities	3,836,319	3,984,507	12,205,231	12,634,273
Medical Costs	(25,147)	(165,957)	(460,945)	(377,513)
Other Expense	20,472,197	20,495,116	64,254,429	60,554,391
Depreciation	16,537,420	16,796,866	49,604,782	50,634,568
Amortization	362,002	362,218	1,113,880	1,174,794
Interest & Taxes	10,888,905	10,766,373	32,972,067	32,931,495
TOTAL EXPENSES	258,231,132	250,269,115	779,283,302	742,910,219
OPERATING INCOME	2,933,875	9,351,490	15,690,528	24,031,831
<u>Nonoperating gains (losses):</u>				
Interest and dividend income	1,983,485	1,751,383	9,334,975	8,696,424
Net realized gains (losses) on the sale of securities	111,912	233,899	352,552	387,543
Change in net unrealized gains on securities	2,013,412	8,950,340	(19,166,946)	(7,519,476)
Derivative related income	1,550,522	1,534,217	4,664,195	4,633,485
Loss on extinguishment of LTD / derivatives	0	0	0	0
Change in estimated fair value of derivatives	(1,833,072)	4,708,408	(124,617)	6,749,512
Gain (loss) on discontinued operations	(2,655,942)	(840,457)	(6,815,529)	(5,626,091)
Other nonoperating gains (losses)	(1,273,282)	(1,519,753)	(3,212,265)	(1,683,812)
Noncontrolling interests in subsidiaries	(2,996,534)	(5,565,027)	(6,986,224)	(8,867,717)
NET NONOPERATING GAINS	(3,099,498)	9,253,010	(21,953,859)	(3,230,133)
EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	(165,623)	18,604,500	(6,263,330)	20,801,698
EBITDA	27,442,362	32,881,395	96,718,962	106,345,229

MOUNTAIN STATES HEALTH ALLIANCE (Consolidated)
 UNAUDITED QUARTERLY DISCLOSURE - FY 2016 - Third Quarter ending March 31, 2016
 Historical Maximum Annual Debt Service Coverage

<u>Calculation:</u>	<u>Third Quarter ending March 31, 2016</u>	<u>Twelve Months ending March 31, 2016</u>
Income available for debt service		
Excess of revenue over expenses (before extraord. items)	\$ (345,964)	\$ 32,371,179
Plus depreciation expense	\$ 16,537,419	\$ 66,180,541
Plus amortization expense	\$ 362,001	\$ 1,496,076
<u>Plus interest expense</u>	\$ 10,888,905	\$ 43,745,099
Subtotal	<u>27,442,362</u>	<u>143,792,895</u>
<i>Annualized quarterly total income available for debt service</i>	<i>x 4</i>	<i>n/a</i>
Total income available for debt service	<u><u>109,769,448</u></u>	<u><u>143,792,895</u></u>
Maximum annual debt service	<u>67,638,000</u>	<u>67,638,000</u>
Maximum annual debt service coverage	<u>1.6</u>	<u>2.1</u>

Exhibit 28

Wellmont's Third Quarter FY2016 Financial Statements

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
March 31, 2016 and June 30, 2015**

**Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years to Date ended
March 31, 2016 and March 31, 2015**

The following financial statements are unaudited and subject to
change upon completion of the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year to Date ended March 31, 2016

Volumes:

Quarter ended March 31, 2016 versus quarter ended March 31, 2015:

Inpatients were down 253 or 3.1% and observation patients increased by 812 or 22.6% (so total "patients in a bed" increased 559 or 4.7%) as we continue to transition to value based payments while facing the challenge of increasingly prevalent high deductible plans in our area.

Emergency room visits were up 5.2%, surgeries were up 2.9%, and deliveries were down 6.9%. Physician office visits were up 15% including urgent care visits which were up 55.2%, due to Wellmont now having eight urgent care centers.

Fiscal Year to Date (Three Quarters):

Inpatients were down 1,180 or 4.7% and observation patients increased 2,377 or 22.4% (so total "patients in a bed" increased 1,197 or 3.4%) as we continue to transition to value based payments while facing the challenge of increasingly prevalent high deductible plans in our area. Emergency room visits were up 2.8%, surgeries were down 3.4%, and deliveries were down 4.8%. Physician office visits were up 10.5% including urgent care visits which were up 42.9%, due to Wellmont now having eight urgent care centers.

Statement of Operations:

Quarter ended March 31, 2016 versus quarter ended March 31, 2015:

Net patient service revenue increased \$13.2 million or 6.9% from the same quarter last year due to (a) an overall 3.1% increase in gross revenue and (b) improved cash receipts. Other revenue decreased \$1.4 million primarily as a result of zero Electronic Health Record Meaningful Use amounts earned during the quarter being \$1.0 million below the prior year amounts of \$1.0 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments.

Salaries and benefits increased \$5.7 million or 5.8% due primarily to (a) the increase in physician office visits and (b) an increase in employee health plan costs. Supplies increased \$1.8 million or 4.4% primarily due to higher infusion volumes. Purchased services increased \$5.1 million or 30.1% primarily due to potential merger expenses. Interest expense decreased \$0.3 million or 6.7% due to scheduled reductions in debt. Depreciation was essentially unchanged. All other expenses decreased \$1.3 million primarily due (a) lower professional and general liability expense from improved actuarial reports and (b) planned elimination of maintenance and pre-Epic systems.

Income from operations of \$1.1 million was above the same quarter last year by \$0.8 million. Net income (loss) (shown as "Revenues and gains in excess of expenses and losses

attributable to Wellmont Health System”) of \$(8.7 million) was below the same quarter last year by \$11.0 million due primarily to realized investment losses from a portfolio rebalance.

Fiscal Year to Date (Three Quarters):

Net patient service revenue increased \$16 million or 2.7% compared to the prior fiscal year to date due to (a) an overall 1.6% increase in gross revenue and (b) the successful implementation of ICD-10 and improved cash receipts. Other revenue decreased \$3.0 million primarily as a result of (a) \$0.1 million of Electronic Health Record Meaningful Use amounts earned being \$2.5 million below the prior year amounts of \$2.6 million due to reduced payments from lower volumes and the scheduled annual decreases in the program’s payments, (b) blood bank revenue reductions of \$0.4 million due to the loss of a significant contract.

Salaries and benefits increased \$7.9 million or 2.7% due primarily to (a) the increase in physician office visits and (b) an increase in employee health plan costs. Supplies were flat. Purchased services increased \$8.7 million or 15.3% primarily due to potential merger expenses. Interest expense decreased \$1.6 million or 12.2% due to scheduled reductions in debt and the effect of the 2014 refinancing activities. Depreciation was essentially unchanged. All other expenses decreased \$3.2 million primarily due to (a) lower professional and general liability expense from improved actuarial reports and (b) planned elimination of maintenance and pre-Epic systems.

Income from operations of \$7.0 million was above the prior fiscal year to date by \$1.6 million. Net income (shown as “Revenues and gains in excess of expenses and losses attributable to Wellmont Health System”) of \$11.3 million was below the prior fiscal year to date by \$2.5 million due to realized investment losses from a portfolio rebalance.

Balance Sheet and Ratios:

The only significant changes in the balance sheet were (a) normal liquidation of fiscal year end accounts payable and accrued expenses (b) decrease in assets limited as to use resulting from unrealized losses on the investment portfolio.

The debt to capitalization ratio, debt service coverage ratio, and days cash on hand were all relatively unchanged.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal years to date ended March 31, 2016 and March 31, 2015.

	FY16 QTR 3	FY15 QTR 3	FY16 YTD	FY15 YTD
Hospital Statistics:				
Acute Discharges	8,038	8,291	23,885	25,065
Observation Patients	4,398	3,586	12,998	10,621
Patients in Bed	12,436	11,877	36,883	35,686
Patient Days	35,452	38,164	104,013	110,918
Average Length of Stay (Days)	4.41	4.60	4.35	4.43
Daily Census including Observations	438	464	425	444
Emergency Room Visits	44,184	41,999	136,546	132,891
Deliveries	469	504	1,496	1,572
Surgical Cases:				
Inpatient	2,209	2,257	6,634	6,886
Outpatient	5,916	5,642	17,843	18,464
Total Surgical Cases	8,125	7,899	24,477	25,350
Physician Office Visits				
including Urgent Care Visits	131,434	114,255	383,951	347,588
	25,053	16,147	67,649	47,348

The following table shows the percentage of gross patient service revenue by payor for the fiscal year to date ended March 31, 2016 and the fiscal year ended June 30, 2015.

	FY16 YTD	FY15 All Year
Medicare	28.1%	30.0%
Medicare Managed Care	26.5%	24.2%
Medicaid	11.9%	11.7%
Managed Care/Other	28.2%	27.9%
Self	5.3%	6.2%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of March 31, 2016 and June 30, 2015
(Dollars in Thousands)(Unaudited)

	<u>As of</u>	<u>As of</u>
Assets	3/31/16	6/30/15
Current assets:		
Cash and cash equivalents	\$62,427	\$ 48,866
Assets limited to use that are required for current liabilities	3,677	3,651
Patient accounts receivable	104,716	112,299
Other receivables	10,494	11,238
Inventories	17,344	19,981
Prepaid expenses & other current assets	7,776	9,979
Total current assets	206,434	206,014
Assets limited as to use, net of current portion	414,776	424,864
Land, buildings and equipment, net	463,370	484,569
Other assets:		
Long-term investments	25,490	27,964
Investments in affiliates	7,143	7,214
Deferred debt expense, net	4,005	4,217
Goodwill, net	51,546	51,583
Other	526	525
	88,710	91,503
Total assets	\$ 1,173,290	\$ 1,206,950
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	\$18,130	\$ 18,626
Accounts payable and accrued expenses	84,065	101,871
Estimated third-party payor settlements	13,119	12,987
Current portion of other long-term liabilities	5,910	7,660
Total current liabilities	121,224	141,144
Long-term debt, less current portion	465,062	480,187
Other long-term liabilities, less current portion	40,966	39,097
Total liabilities	627,252	660,428
Net assets:		
Unrestricted	534,865	535,632
Temporarily restricted	6,946	6,960
Permanently restricted	1,325	1,323
Noncontrolling interests	2,902	2,607
Total net assets	546,038	546,522
Commitments and contingencies		
Total liabilities and net assets	\$ 1,173,290	\$ 1,206,950

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years to date ended March 31, 2016 and March 31, 2015
(Dollars in Thousands)(Unaudited)

	FY16 QTR 3	FY15 QTR 3	FY16 YTD	FY15 YTD
Revenue:				
Net patient service revenue less provision for bad debts	\$ 203,749	\$ 190,535	\$ 601,562	\$ 585,489
Other revenue	4,224	5,581	13,470	16,459
Total revenue	<u>207,973</u>	<u>196,116</u>	<u>615,032</u>	<u>601,948</u>
Expenses:				
Salaries and benefits	103,655	97,962	299,739	291,805
Medical supplies and drugs	43,226	41,418	126,626	126,701
Purchased services	22,159	17,029	65,357	56,663
Interest	3,892	4,170	11,703	13,329
Depreciation and amortization	14,237	14,179	42,865	43,141
Maintenance and utilities	8,154	9,519	27,272	29,725
Lease and rental	3,975	3,874	11,946	11,389
Other	7,603	7,646	22,552	23,856
Total expenses	<u>206,901</u>	<u>195,797</u>	<u>608,060</u>	<u>596,609</u>
Income from operations	<u>1,072</u>	<u>319</u>	<u>6,972</u>	<u>5,339</u>
Nonoperating gains (losses):				
Investment income	(9,579)	2,376	4,793	11,679
Derivative valuation adjustments	38	726	72	1,134
Loss on refinancing	-	-	-	(1,389)
Nonoperating gains (losses), net	<u>(9,541)</u>	<u>3,102</u>	<u>4,865</u>	<u>11,424</u>
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	(8,469)	3,421	11,837	16,763
Discontinued operations	-	(691)	-	(2,188)
Revenues and gains in excess of expenses and losses	<u>(8,469)</u>	<u>2,730</u>	<u>11,837</u>	<u>14,575</u>
Income attributable to noncontrolling interests	<u>(258)</u>	<u>(496)</u>	<u>(549)</u>	<u>(793)</u>
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	(8,727)	2,234	11,288	13,782
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	15,432	3,206	(16,024)	(14,395)
Net assets released from restrictions for additions to land, buildings, and equipment	737	1,187	3,969	2,328
Increase (decrease) in unrestricted net assets	<u>7,442</u>	<u>6,627</u>	<u>(767)</u>	<u>1,715</u>
Changes in temporarily restricted net assets:				
Contributions	1,481	488	4,610	2,375
Net assets released from temporary restrictions	(1,116)	(1,498)	(4,624)	(3,131)
Increase (decrease) in temporarily restricted net assets	<u>365</u>	<u>(1,010)</u>	<u>(14)</u>	<u>(756)</u>
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	-	-	2	3
Increase (decrease) in permanently restricted net assets	<u>-</u>	<u>-</u>	<u>2</u>	<u>3</u>
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	258	496	549	793
Distributions to noncontrolling interests	(116)	(337)	(254)	(612)
Increase (decrease) in noncontrolling interests	<u>142</u>	<u>159</u>	<u>295</u>	<u>181</u>
Change in net assets	7,949	5,776	(484)	1,143
Net assets, beginning of period	538,089	546,197	546,522	550,830
Net assets, end of period	<u>\$ 546,038</u>	<u>\$ 551,973</u>	<u>\$ 546,038</u>	<u>\$ 551,973</u>

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years to date ended March 31, 2016 and March 31, 2015
(Dollars in Thousands)(Unaudited)

	FY16 YTD	FY15 YTD
Cash flows from operating activities:		
Change in net assets	\$ (484)	\$ 1,143
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	42,865	43,141
Net realized and unrealized (gains) losses on investments	11,231	2,716
Derivative valuation adjustments	(72)	(1,134)
(Gain) loss on sale of fixed assets	(416)	(542)
Loss on refinancing	0	1,389
Increase (decrease) in cash due to changes in:		
Accounts Receivable	7,583	6,368
Inventories	2,637	(870)
Prepaid expenses and other current assets	2,577	5,157
Accounts payable and accrued expenses	(15,092)	(29,683)
Net decrease (increase) in other assets	757	16,997
Net cash provided by operating activities	51,586	44,682
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(23,965)	(31,402)
Transfer (to)/from Bond and Self-Insurance funds	1,561	(857)
Transfer (to)/from Board funds	0	0
Net cash (used) in investing activities	(22,404)	(32,259)
Cash flows from financing activities:		
Proceeds from long term debt	0	22,415
Repayment of long term debt	(15,621)	(33,789)
Net cash provided (used) in financing activities	(15,621)	(11,374)
Increase (decrease) in cash and cash equivalents	13,561	1,049
Cash and cash equivalents, beginning	48,866	30,674
Cash and cash equivalents, ending	\$ 62,427	\$ 31,723

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

	3/31/16	6/30/15
<u>Capitalization</u>		
Current portion of long-term debt	\$ 18,130	\$ 18,626
Short-term notes payable	-	-
Long-term debt, less current portion	A 465,062	480,187
Total debt	<u>483,192</u>	<u>498,813</u>
Unrestricted net assets	B 534,865	535,632
Other net assets	11,173	10,890
Total net assets	<u>546,038</u>	<u>546,522</u>
Long-term debt plus Unrestricted net assets	A+B \$ 999,927	\$ 1,015,819
Long-term debt to Capitalization	A/(A+B) 0.465	0.473
<u>Debt Service Coverage</u>		
Revenue and gains in excess of expenses and losses (12 months)	\$ 12,869	\$ 15,363
Add back:		
Depreciation and amortization (12 months)	58,293	58,569
Interest expense (12 months)	16,131	17,757
(Gain) loss on refinancing (12 months)	-	1,389
(Gain) loss from discontinued operations (12 months)	4,908	2,720
Total income available for debt service per Master Trust Indenture	C <u>92,201</u>	<u>95,798</u>
Maximum annual debt service	D \$ 42,972	\$ 43,009
Debt Service Coverage Ratio per Master Trust Indenture	C/D 2.15	2.23
<u>Days Cash on Hand</u>		
Unrestricted cash	\$ 62,427	\$ 48,866
Unrestricted investments:		
Capital improvements	373,396	382,902
Long-term investments	25,490	27,964
Less illiquid investments	(26,248)	(28,051)
	E <u>435,065</u>	<u>431,681</u>
Operating expenses (12 months)	817,487	806,035
Less depreciation and amortization	(58,293)	(58,569)
Total cash expenses	<u>759,194</u>	<u>747,466</u>
Number of days in the period	366	365
Daily cash operating expenses	F \$ 2,074	\$ 2,048
Days cash on hand	E/F <u>209.7</u>	<u>210.8</u>

Exhibit 29

Details Regarding Mountain States' Severance Packages

To be submitted pursuant to CID.

Exhibit 30

Details Regarding Wellmont's Severance Packages

To be submitted pursuant to CID.

Exhibit 31

Proposed Employment Agreements with New Health System

To be submitted pursuant to CID.

Exhibit 32

Physician needs Assessment from Niswonger Children's Hospital

To be submitted pursuant to CID.

Exhibit 33

Audited Results for FY2011 to FY2015

MOUNTAIN STATES HEALTH ALLIANCE

Consolidated Statements of Operations

	2015	2014	2013	2012	2011
Revenue, gains and support:					
Net patient service revenue, net of contractual allowances and discounts	\$ 1,116,954,225	\$ 1,050,425,742	\$ 1,045,244,653	\$ 1,075,050,313	\$ 1,062,122,920
Provision for bad debts	(127,519,531)	(122,641,687)	(112,497,088)	(122,917,014)	(116,248,346)
	989,434,694	927,784,055	932,747,565	952,133,299	945,874,574
Other operating revenue	73,345,726	71,043,732	64,140,484	39,406,853	24,868,175
TOTAL REVENUE, GAINS AND SUPPORT	1,062,780,420	998,827,787	996,888,049	991,540,152	970,742,749
Expenses:					
Salaries and wages	345,155,144	340,589,134	355,589,870	358,607,181	342,208,116
Physician salaries and wages	80,279,380	77,636,096	74,257,857	65,706,003	59,248,825
Contract labor	5,415,831	4,282,340	3,941,874	6,375,067	5,963,696
Employee benefits	77,306,084	69,173,499	74,589,762	69,599,641	67,138,834
Fees	120,691,188	115,606,412	105,890,846	97,958,613	85,918,931
Supplies	176,049,710	163,698,766	162,955,174	170,186,051	168,261,321
Utilities	16,775,020	17,052,090	16,857,010	17,289,136	17,300,381
Medical costs	18,382,989	10,292,244	1,039,401	-	-
Other	81,477,121	79,979,993	80,211,445	76,285,343	69,647,165
Depreciation	67,210,326	69,436,735	78,941,071	73,059,635	87,499,468
Amortization	1,556,991	1,741,757	2,259,537	2,245,327	2,559,141
Interest and taxes	43,695,597	44,391,756	43,202,890	45,902,804	44,152,737
TOTAL EXPENSES	1,033,995,381	993,880,822	999,736,737	983,214,801	949,898,615
OPERATING INCOME (LOSS)	28,785,039	4,946,965	(2,848,688)	8,325,351	20,844,134
Nonoperating gains (losses):					
Interest and dividend income	13,893,945	12,073,668	13,880,727	15,212,951	16,224,492
Net realized gains (losses) on the sale of securities	9,260,235	15,310,531	3,073,768	(2,594,831)	1,956,855
Net unrealized gains on securities	(6,137,785)	23,317,890	24,024,957	(2,884,095)	22,168,047
Derivative related income	6,171,935	5,979,869	6,661,242	7,514,566	5,072,334
Loss on early extinguishment of debt	-	(4,622,060)	-	(2,636,010)	-
Change in estimated fair value of derivatives	7,718,028	(2,761,314)	456,715	(6,197,514)	23,048,906
Other nonoperating gains (losses)	(4,590,695)	2,097,601	14,318,127	11,235,840	(2,652,743)
NET NONOPERATING GAINS (LOSSES)	26,315,663	51,396,185	62,415,536	19,650,907	65,817,891
EXCESS (DEFICIT) OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES	\$ 55,100,702	\$ 56,343,150	\$ 59,566,848	\$ 27,976,258	\$ 86,662,025

Exhibit 34

Exhibit 11.5 - Attachment C Wellmont EMMA - Annual Disclosures for 2011 to 2015

WELLMONT CFO TO LEAVE HEALTH SYSTEM, SERVE AS TREASURER DURING TRANSITION

KINGSFORT – Beth Ward, who has successfully guided Wellmont Health System’s financial strategies as chief financial officer for the past 18 months, will be leaving that post to pursue new professional opportunities.

“Health systems across the country have recently faced significant financial challenges from changing healthcare legislation to a downturn in the national economy,” said Denny DeNarvaez, president and CEO of Wellmont. “We are extremely fortunate to have had Beth’s leadership and remarkable stewardship of our finances during these times.”

The search for a replacement is underway. During the transitional period, Ward will continue serving as Wellmont’s treasurer, with the primary responsibilities of overseeing investments, debt management and bank and bondholder relationships.

“Our organization is better because of Beth’s service with us, and we look forward to her continued service in this new interim role over the coming months,” DeNarvaez said. “We also wish her the very best as she pursues her next career path.”

###

Wellmont Health System announces Lee Regional Medical Center closing in wake of healthcare reform; hospital to help patient, co-workers transition

Despite significant efforts by hospital administrators and the local board of directors to secure its future, Lee Regional Medical Center will join the list of hospitals across the country to close in an era of unprecedented changes to health care. Lee Regional Medical Center, located in Pennington Gap, Virginia, represents 2% of Wellmont Health System's operating revenue and this closure will not impact debt service coverage as this is excluded from the calculations under the Wellmont Health System Master Trust Indenture.

Three issues are the primary reasons that have led to this decision – reimbursement cuts associated with the Affordable Care Act, extremely low community use of the hospital and a lack of consistent physician coverage.

Lee Regional will cease all operations on Oct. 1, but patients who need a broad spectrum of care will still have seamless access to other Wellmont Health System facilities in the community and throughout the region. Wellmont Medical Associates will work with other community partners to assess what outpatient services are most needed and how those could be best served in the region.

“We had certainly hoped Lee Regional could remain open as a hospital and continue serving the community, but the difficult realities facing our facility are too much to overcome,” said Fred Pelle, the hospital's interim president. “We remain committed to serving the health needs of people who live and work in Lee County and will assist them in whatever way possible in this transition.”

The closure is due in part to major cuts in Medicare reimbursements by the federal government associated with the Affordable Care Act and a lack of Medicaid expansion by the commonwealth of Virginia. Another factor is the additional 2 percent cut in Medicare reimbursements enacted because of the federal sequester.

More than 60 percent of the hospital's payments comes from federal and state programs.

Through the American Hospital Association, hospitals across the country agreed to initial cuts in the reimbursements with the understanding Medicaid would be expanded to compensate for that lost revenue. But the U.S. Supreme Court's ruling on the Affordable Care Act left it to the states to decide whether Medicaid should be expanded.

Virginia has put the issue in the hands of a commission consisting of delegates and senators but reached no conclusion. In the interim, the steep cuts have profoundly impacted the financial ability of hospitals in the region and across the country to survive.

“These political decisions clearly can have dire ramifications for small communities and the hospitals that serve them,” said Denny DeNarvaez, Wellmont's president and CEO. “For months, Wellmont and other health systems in the region and across the country have outlined the consequences of these cuts on community health. While our local legislators have been

understanding, there is simply not a supportive state or national climate overall to effectively resolve this matter.

“The national goal is to reduce costs and keep people out of the hospital. This is a noble initiative, but the cuts are hitting faster than struggling rural hospitals can respond.”

Another matter that has affected Lee Regional’s ability to continue as a hospital is finding physicians to take call coverage at the hospital.

Pelle said physicians who provided call coverage notified Lee Regional administrators that they would no longer provide this service as of Oct. 1.

“Hospitals rely on physicians from the community for call coverage,” Pelle said. “When that coverage is no longer available, no one can appropriately manage patient care in the hospital. We cannot create the quality or environment of care the community needs and deserves without a reservoir of physician coverage.”

Additional efforts to work with these physicians on a potential solution produced no plan that was sustainable for the hospital and the community, Pelle said.

The hospital has also experienced financial challenges due to a decrease in the number of patients in an economically distressed community obtaining care at the hospital. The hospital made several changes to respond to changing patient needs and reduced revenue, including reducing inpatient and intensive care services.

“Unfortunately, since that time, community usage of the hospital has continued to decline to an average daily census of only a handful of patients,” Pelle said. “Emergency department and outpatient volumes have also fallen during this time. Even though we made appropriate adjustments in our staffing volumes, the financial losses were expected to be \$4 million or more per year in the coming years.”

Pelle said Lee Regional is focused on helping co-workers at the hospital obtain new jobs. The hospital employed about 100 people, roughly 1 percent of the county’s workforce, and these co-workers will receive severance pay. Pelle said these co-workers served Lee Regional and the patients they treated with great pride.

Wellmont Medical Associates will also work relentlessly to help patients obtain the care they need. The community assessment that will be undertaken might lead to the development of after-hours clinics, telemedicine consults, testing, imaging, chronic disease management services, and visiting specialty physician clinics.

Primary care services will continue to be available through the Wellmont Medical Associates practices of Drs. Monika Karakattu, Sidney Gilbert and Patrick Molony in Pennington Gap and Jonesville.

Plus, nearby Lonesome Pine Hospital and Holston Valley Medical Center, which serves dozens of people from Lee County every day, are equipped to treat patients from Lee County. These hospitals have also committed to begin new care management efforts for patients transitioning to home health or nursing homes in the county.

WellmontOne Air Transport and Med-Flight II, which have many of the same pieces of equipment used in Wellmont emergency departments, are also ready to assist patients in Lee County with rapid transport. Whether they reach patients via the helipad that will remain available at Lee Regional or at the scene, paramedics and flight nurses on these aircrafts will be available to deliver lifesaving care. The helicopters can reach Holston Valley in 12 minutes and Bristol Regional Medical Center in 18 minutes from Lee Regional.

In addition, Wellmont has instituted a patient navigation and information service to assist residents of the county with any questions related to accessing the services they need. Medical professionals can also be accessed at any time by calling 1-877-230-NURSE (6877) for general medical questions or assistance scheduling testing or hospital services.

“Do not hesitate to access these services and facilities because they are designed help patients and the community during this transition,” Pelle said. “We have had the honor of serving Lee County for many years with high-quality care, and that will continue to be our approach well into the future.”

WELLMONT HEALTH SYSTEM'S BOARD CHAIRMAN, CEO ISSUE STATEMENTS

KINGSFORT – Roger Leonard, chairman of Wellmont Health System's board of directors, issues the following statement:

After four years of strong leadership for our organization, Denny DeNarvaez has decided the time is right for her to leave her role as CEO of Wellmont.

We are experiencing a period of great transformation here at Wellmont as our board continues its process to explore the right and best path to ensure a future that allows us to thrive for generations to come. It is not unusual during these times of transition that there be a change in leadership.

We thank Denny for her contributions to Wellmont during the most pivotal time ever experienced in the health care industry. Under her leadership, Wellmont has accomplished many important strategic objectives, such as:

- Establishing Wellmont Medical Associates, the Wellmont CVA Heart Institute and the Wellmont Cancer Institute as market leaders
- Introducing the Wellmont LiveWell initiative to improve community health and wellness
- Expanding Wellmont's regional access through new physician offices, testing centers and urgent care centers
- Implementing the Epic electronic health record with record pace and best-practice execution
- Adopting the Healing Environment, which advances the patient- and family-centered focus of our care delivery.

She has also established a strong executive leadership team, which remains to capably assist with this transition. We wish her well in her future endeavors.

During this time of transition, the board and Wellmont's executive leadership team will work together until an interim CEO is identified.

The focus of our board continues to be the work of determining the right strategic direction for Wellmont and health care in our region, and we are encouraged by the options before us.

Denny DeNarvaez, president and CEO, issues the following statement.

I am so proud of all that we have accomplished here at Wellmont during my time as CEO. Every day, our physicians and nurses and co-workers serve tirelessly to bring comfort and healing to patients and their families across the region during the most vulnerable of times.

I thank everyone for welcoming me into the Wellmont family for the past four years, and I hope you will understand my need to transition at this time.

###

Bart Hove Named Wellmont's Interim President And CEO, Brings 37 Years of Health Care Leadership Experience

Bart Hove, who provided impressive leadership as president of Bristol Regional Medical Center for 12 years, has been selected as Wellmont Health System's interim president and CEO.

Hove will begin his service Tuesday, Sept. 16, and bring 37 years of experience in health care administration to the helm of Wellmont. He will head the executive leadership team for a diverse health system that has set a standard of excellence for the region in health care delivery. He will work with Wellmont's corporate team and divisional presidents to build on the strengths of all Wellmont hospitals together with Wellmont Medical Associates, the Wellmont Cancer Institute and the Wellmont CVA Heart Institute.

Hove succeeds Denny DeNarvaez, who recently resigned after four years as president and CEO.

"Bart is a remarkable leader who was instrumental in Wellmont's success during his earlier tenure with us," said Roger Leonard, chairman of the health system's board of directors. "He is familiar with Wellmont's operations and has worked hand in hand with our executive leadership team, so he will hit the ground running.

"We are grateful Bart has agreed to assist us during this important time in Wellmont's history and know his wisdom and experience will benefit our organization considerably as we move forward."

Wellmont's board has been engaged for a year and a half in a thorough evaluation of the health system's long-term future in light of the changing national health care landscape. The board has decided to affiliate with another organization and narrowed the list of organizations it is considering to three. The process is in a due diligence phase, with the board possibly deciding on a partner by the end of the year.

"It's an honor for the board to ask me to work with them as we examine Wellmont's options for the future," Hove said. "I have seen the organization's tremendous growth and innovation and witnessed sensational care delivered every day by our outstanding physicians, nurses and other dedicated medical professionals. This will only accelerate as Wellmont takes the next step in its development of the best health care anywhere."

During his time at Bristol Regional, the hospital elevated the quality of care through multiple initiatives. Bristol Regional was designated a Primary Stroke Center and greatly expanded its emergency department and Level II trauma center. The hospital also bolstered its oncology and interventional cardiology programs with new facilities and became the regional leader in robotics with CyberKnife Robotic Radiosurgery System and da Vinci Surgical System. While with Wellmont, Hove was selected as the 2009 recipient of the Tennessee Hospital Association's meritorious service award.

"With the help of so many people, we greatly enhanced the caliber of care through a progressive spirit across Wellmont," Hove said. "Holston Valley Medical Center, our community division hospitals and our

outpatient facilities also found additional ways to remain on the cutting edge of health care. It was a pleasure to be part of a team that was constantly looking for ways to deliver optimal health care for our region.”

Prior to joining Wellmont, Hove served as CEO of Delta Regional Medical Center in Greenville, Mississippi; president and CEO of Good Samaritan Hospital in Lexington, Kentucky; CEO of Crestwood Hospital in Huntsville, Alabama; and administrator of Beaches Hospital in Jacksonville, Florida. He was a longtime fellow of the American College of Healthcare Executives.

Hove received a bachelor’s degree from the Georgia Institute of Technology in Atlanta and a master’s degree in hospital administration from the University of Alabama in Birmingham.

###



FOR IMMEDIATE RELEASE 1/5/10

**WELLMONT CEO MIKE SNOW ACCEPTS OPPORTUNITY TO LEAD
NATIONAL HOME HEALTH COMPANY**

Snow will lead Wellmont through transition period; board to identify interim CEO

KINGSPORT – Mike Snow, who has served as president and CEO of Wellmont Health System since 2008, has been named chief operating officer of Amedisys Inc. (NASDAQ: AMED), a \$1.5 billion, publicly traded home health nursing company based in Baton Rouge, La.

Snow will remain at Wellmont through a transition period. With Snow's assistance, the Wellmont board of directors is in the process of identifying an interim CEO and expects to make an appointment by the end of February.

"Mike came to Wellmont to help improve our financial and competitive position, while leading with integrity and vision. He has achieved that mission in spades," said Roger K. Mowen Jr., chairman of the Wellmont board of directors. "We are grateful for his successful efforts to guide Wellmont through a financial review and restatement, update Wellmont's strategic plan and implement improvements that have materially improved annual operating income. Mike has put Wellmont on stronger financial and competitive footing. We wish him the very best in this next chapter of his career."

Snow said he is proud to have worked with Wellmont's employees, physicians and leaders to realize the health system's mission to deliver superior health care with compassion.

"Wellmont is a terrific organization, and I leave knowing I have accomplished what I came here to do – to strengthen the organization operationally and financially and position it for continued success," Snow said. "I am committed to working with the board of directors and leadership team to ensure a smooth transition and will continue to play an active role in identifying an interim CEO to serve as my replacement.

"I will miss all of the talented people at Wellmont but am looking forward to working closer to my family."

Wellmont will continue to operate as usual during this leadership transition. Despite a challenging economy, the health system is performing well and continues to improve.

For the first quarter of the 2010 fiscal year (which ended Sept. 30), income from operations was \$9.3 million, or more than 50 percent (or \$3.2 million) ahead of the budget of \$6.1 million. During the period, surgeries, ER visits and observation volumes were up slightly compared to the prior year's first quarter, while acute discharges decreased slightly.

In August, Standard & Poor's upgraded its outlook on Wellmont to stable, citing the system's "improving financial metrics" and "better-than-expected operating performance." In addition, S&P affirmed Wellmont's BBB+ credit rating.

As previously announced, Beth Ward, a certified public accountant with more than 25 years experience in healthcare finance, will join Wellmont's executive leadership team as chief financial officer this month. Ward will provide assistance with the selection of a new CEO.

"We are fully committed to appointing a CEO of the highest quality to replace Mike," Mowen said. "Our patients, employees, physicians and volunteers deserve an equally qualified and visionary leader."

About Wellmont Health System: Wellmont Health System is a premier provider of healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers.

###

WELLMONT NAMES BOB BURGIN INTERIM CEO

KINGSPORT – Bob Burgin, a retired healthcare executive who served for more than two decades as president and CEO of Mission Hospitals in Asheville, N.C., will provide interim leadership for [Wellmont Health System](#) as the organization conducts a national search for its next chief executive.

Burgin has been as a member of the Wellmont board of directors since July 2009. He assumes his responsibilities as interim CEO today, working closely with outgoing President and CEO Mike Snow, who will leave the system later this month to become chief operating officer of Amedisys Inc.

“Bob’s exemplary record at Mission speaks for itself, and he has demonstrated a keen understanding of the opportunities and challenges facing our hospitals during his tenure on the Wellmont board,” said Roger K. Mowen Jr., board chairman. “His experience as a Wellmont board member enables him to hit the ground running, which is a tremendous benefit to our organization and the patients we serve.

“Bob is an experienced leader who will provide strong, steady leadership for our health system during this time of transition.”

Burgin served as Mission’s president and CEO for nearly 24 years before his retirement in 2004. The organization was repeatedly recognized for its quality of care and efficient operations under his leadership. Following his retirement, he was named Mission’s president emeritus. He also worked with Mission’s foundation for three years after retirement.

Burgin previously served as chief operating officer of UNC Hospitals’ North Carolina Memorial Hospital in Chapel Hill. He was also a captain in the Army Medical Service Corps.

He is a graduate of Miami University in Ohio, where he received a bachelor’s degree in history and economics, and the University of Michigan, where he earned a master’s degree in health services administration. Burgin has also completed executive programs in health policy and management at Harvard University.

Since his retirement, Burgin has served as a consultant with KPMG in Atlanta and has done extensive consulting for law firms. He has also provided management assistance to an anesthesia management company.

He and his wife have two grown children.

With Burgin's selection as interim CEO, Mowen said, the Wellmont board of directors will now turn its attention to a national search for a permanent president and CEO. The board will work with an executive search firm to identify and select a top candidate, a process expected to be complete within six months.

"As stewards of our communities' hospitals, our board members take this responsibility seriously," Mowen said. "We are committed to a thorough, deliberate search process to identify a leader with both the character and competence to lead our organization in support of our mission to deliver superior health care with compassion."

###



FOR IMMEDIATE RELEASE **6/4/10**
CONTACT: Amy Stevens
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**WELLMONT NAMES ACCOMPLISHED EXECUTIVE
MARGARET ‘DENNY’ DENARVAEZ PRESIDENT AND CEO**

KINGSPORT – Margaret “Denny” DeNarvaez, who has provided executive leadership for one of the country’s largest faith-based health systems and led a hospital nationally recognized for excellence in cardiac care, has been named president and CEO of Wellmont Health System.

DeNarvaez will assume her new responsibilities Aug. 1, succeeding interim CEO Bob Burgin. She was the unanimous selection of the Wellmont board of directors following a national search process.

“Our search for the right CEO was a thorough, deliberate exercise involving board members, physicians, employees and community leaders,” said Roger K. Mowen Jr., chairman of the Wellmont board. “After meeting Denny and seeing firsthand her commitment to excellence and passion for service, every participant in the search process came away with the same strong conviction – this is the right person at the right time for Wellmont Health System, our hospitals and the communities we serve.

“There’s a lot of uncertainty in health care these days surrounding healthcare reform, but there’s one thing of which I am absolutely certain. With Denny’s leadership, our hospitals will build upon our already strong record of clinical and operational excellence. And we’ll remain squarely focused on our mission to deliver superior health care with compassion.”

DeNarvaez, 54, has more than 27 years’ experience in healthcare leadership. She presently serves as CEO of St. John’s Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provides leadership for Mercy’s extensive Missouri and Oklahoma operations, which encompass more than 2,200 licensed beds, nearly 15,000 employees and nearly 3,000 physicians.

As president and CEO of St. John’s Mercy Health Care, she oversees the fiscal, strategic

(MORE)

CEO

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and operational initiatives of multiple facilities, including the 979-bed St. John's Mercy Medical Center. This fully accredited teaching hospital operates St. Louis County's only Level I trauma Center and Level III neonatal intensive care unit.

During her five-year tenure with the Mercy system, DeNarvaez has refocused the organization on its mission, vision and values, led a multimillion-dollar financial turnaround, established a dedicated heart hospital and developed a physician clinical council to leverage the experience and judgment of physicians in operations and planning. Under her leadership, St. John's Mercy has been recognized as a "best place to work" by both the *St. Louis Business Journal* and *Modern Healthcare* magazine.

DeNarvaez previously served as president of Abbott Northwestern Hospital in Minneapolis, part of Allina Hospitals and Clinics. Abbott Northwestern, the largest hospital in Minnesota's Twin Cities, is nationally recognized for clinical expertise in cardiac care through its renowned Minneapolis Heart Institute.

She has also served as CEO and chief financial officer of Florida Medical Center in Fort Lauderdale, Fla.

"It's not often in a person's career you have the opportunity to marry a great job with a great location," DeNarvaez said. "To lead Wellmont Health System, a premier healthcare system, while living in an area we have visited for the past 30 years is a blessing.

"My parents – now both in their 80s – will be within commuting distance. Equally appealing, however, is the opportunity to leverage the great work that has been done to date to make Wellmont a preferred healthcare provider. I feel privileged to have been selected to lead during this chapter in Wellmont's history."

DeNarvaez is a graduate of Drake University in Fort Lauderdale, where she earned a bachelor's degree of business administration in accounting. She is a certified public accountant and holds leadership certifications from the University of Michigan Business School in Ann Arbor and the University of St. Thomas in St. Paul, Minn.

She was the 2009 recipient of the Visionary Leadership Award from the Missouri Hospital Association and in 2007 was named one of the Top 25 most influential businesswomen by the *St. Louis Business Journal*.

About Wellmont Health System: Wellmont Health System is a premier provider of

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CEO

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healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont hospitals offer a broad scope of services ranging from community-based acute care to highly specialized tertiary services including two trauma centers.

###

Denny DeNarvaez

Margaret “Denny” DeNarvaez will become president and CEO of Wellmont Health System Aug. 1. An accomplished executive with nearly 30 years of healthcare experience, DeNarvaez presently serves as CEO of St. John’s Mercy Health Care, which includes hospitals in both St. Louis and Washington, Mo. DeNarvaez also provides leadership for Mercy’s extensive operations in Missouri and Oklahoma, encompassing more than 2,200 licensed beds, nearly 15,000 employees and nearly 3,000 physicians.



During her five-year tenure with the Mercy system, DeNarvaez has refocused the organization on its mission, vision and values, led a multimillion-dollar financial turnaround, established a dedicated heart hospital and developed a physician clinical council to leverage the experience and judgment of physicians

in operations and planning. Under her leadership, St. John’s Mercy has been recognized as a “best place to work” by both the St. Louis Business Journal and Modern Healthcare magazine.

DeNarvaez previously served as president of Abbott Northwestern Hospital in Minneapolis, part of Allina Hospitals and Clinics. Abbott Northwestern, the largest hospital in Minnesota’s Twin Cities, is nationally recognized for clinical expertise in cardiac care through its renowned Minneapolis Heart Institute. She has also served as CEO and chief financial officer of Florida Medical Center in Fort Lauderdale, Fla.

DeNarvaez is a graduate of Drake University in Fort Lauderdale, where she earned a bachelor’s degree of business administration in accounting. She is a certified public accountant and holds leadership certifications from the University of Michigan Business School in Ann Arbor and the University of St. Thomas in St. Paul, Minn.

She was the 2009 recipient of the Visionary Leadership Award from the Missouri Hospital Association and in 2007 was named one of the Top 25 most influential businesswomen by the St. Louis Business Journal.

\$200,000,000
The Health, Educational and Housing
Facilities Board of the County of Sullivan,
Tennessee
Hospital Revenue Bonds
(Wellmont Health System Project),
Series 2006C

CUSIP Numbers: (Base: 865293)
AC8, AD6, AE4, AF1

\$55,000,000
Virginia Small Business Financing
Authority
Hospital Revenue Bonds
(Wellmont Health System Project),
Series 2007A

CUSIP Numbers: (Base: 928101)
AA2, AB0, AC8

MATERIAL EVENT NOTICE

The Health, Educational and Housing Facilities Board of the County of Sullivan, Tennessee (the "TN Issuer") issued the Hospital Revenue Bonds (Wellmont Health System Project), Series 2006C (the "Series 2006C Bonds"), on November 2, 2006 and the Virginia Small Business Financing Authority issued the Hospital Revenue Bonds (Wellmont Health System Project), Series 2007A (the "Series 2007A Bonds") on July 31, 2007, both for the benefit of Wellmont Health System (the "Borrower").

In connection with the issuance of the Series 2006C Bonds and the Series 2007A Bonds, the Borrower undertook to provide each nationally recognized municipal securities information repository certain notice and information regarding certain material events pursuant to Rule 15c2-12 of the Securities Exchange Commission.

In connection with the expected issuance of a revenue and refunding bond by the TN Issuer for the benefit of the Borrower, on September 24, 2014 the Borrower expects to execute and deliver (i) a Master Trust Indenture (the "Amended and Restated Master Indenture") among the Borrower, Wellmont Hawkins County Memorial Hospital, Inc., Wellmont, Inc. and Wellmont Foundation (the "Obligated Group") and U.S. Bank National Association, as master trustee (the "Master Trustee"), to amend and restate the existing Master Trust Indenture dated as of May 1, 1991 (the "Original Master Indenture"), among the Obligated Group and the Master Trustee and (ii) certain amendments (the "Deed of Trust Amendments") to the existing deeds of trust (the "Original Deeds of Trust" and together with the Deed of Trust Amendments, the "Deeds of Trust") securing obligations secured under the Original Master Indenture.

In connection with the issuance of both the Series 2006C Bonds and the Series 2007 Bonds, the Borrower executed and delivered its promissory note for the benefit of the respective bondholders (each a "Note"). Each Note was issued as an "obligation" under the Original Master Indenture.

The Amended and Restated Master Indenture and the Deed of Trust Amendments will (i) modify the rights of holders of all obligations secured under the Original Master Indenture,

including the holders of the Series 2006C Bonds and the Series 2007 Bonds, and (ii) result in a release of certain real property currently subject to the Original Deeds of Trust.

A current draft of the Amended and Restated Master Indenture is on file with the Master Trustee. For a copy please contact Wally Jones, 615.251.0733 or wally.jones@usbank.com.

The Borrower's real and personal property with respect to Wellmont Bristol Regional Medical Center and Wellmont Holston Valley Regional Medical Center will continue to be subject to the Deeds of Trust; however, the Borrower's headquarters building, certain medical office buildings and non-hospital facilities, certain undeveloped land and the two hospitals located in Virginia will no longer be subject to the Deeds of Trust.

Simultaneously with the distribution of this Material Event Notice, the Borrower has caused the distribution of a notice of refunding with respect to the refunding of a portion of the outstanding principal amount of the Hospital Revenue Bonds (Wellmont Health System Project), Series 2006C.

WELLMONT HEALTH SYSTEM

Dated: August 21, 2014

ALICE POPE, AN ACCOMPLISHED WELLMONT SENIOR LEADER, NAMED CHIEF FINANCIAL OFFICER

KINGSPORT – Alice Pope, a respected healthcare finance executive and a senior leader at Wellmont Health System for the last three years, has been promoted to chief financial officer.

Pope has most recently served as senior vice president of finance, managed care and revenue cycle. A certified public accountant, she has been entrusted with increasing responsibilities during her 12-year career with Wellmont.

“After a national search, it is very gratifying to find the best candidate within Wellmont to guide our financial operations,” said Denny DeNarvaez, president and CEO. “Alice has a proven track record of outstanding financial stewardship, which has benefited Wellmont and the region greatly.”

In her service as senior vice president, Pope has been instrumental in enhancing corporate treasury operations and in realizing significant improvements in the system’s revenue cycle functions, including managed care contracting and system case management.

Pope has played an essential role in recent physician practice integrations, which have resulted in Wellmont having the largest collective number of pulmonologists, sleep specialists, oncologists and cardiovascular physicians in Northeast Tennessee and Southwest Virginia.

She was also a key figure in the development of the region’s first focused network with Cigna, an insurance provider that covers more than 40,000 local lives. Cigna provides health insurance plans for several major employers, including Eastman Chemical Co., and the focused network blended high-quality healthcare services and physicians with reduced costs for employers and employees.

During her tenure in the executive leadership team, Wellmont has consistently improved many of its financial metrics and achieved important benchmarks.

An early highlight in Pope’s Wellmont career was her service from 2003-08 as vice president and chief financial officer of Holston Valley Medical Center, Wellmont’s largest hospital. She was intimately involved in the development and implementation of Project Platinum, Holston Valley’s \$114 million expansion and renovation project completed in 2010.

“Alice understands the values of our organization, is committed to its success and possesses the expertise and leadership skills that will ensure Wellmont is fiscally strong well into

the future,” DeNarvaez said. “Her integrity and impressive leadership will also serve as excellent models as we further develop successful methods to protect and grow our financial resources.”

Pope said she is grateful for the opportunity to take the next step to grow professionally and continue to build Wellmont’s reputation in the region.

“Wellmont is well positioned for success amid the changing dynamics of health care,” she said. “Although there are many challenges on the horizon, we will use them as steppingstones to achieve an enhanced care model for the communities we are privileged to serve. We have a great team that has helped us remain the region’s highest-quality, lowest-cost healthcare provider.”

To continue leading the way, Pope said co-workers in Wellmont’s financial operations – and everyone else who works for the system – will need to be innovative.

“Our future success depends on our ability to be disciplined, agile and adaptable to thrive in some tough financial realities,” she said. “I’m excited to accept this opportunity for an organization I value so much.”

Before Pope joined Wellmont, she served as chief financial officer of Baptist Memorial Health Care Corp.’s Mississippi market and as an audit manager with Arthur Andersen.

Pope earned a bachelor’s degree in commerce, with a concentration in accounting, from the University of Virginia and a master’s in business administration from East Tennessee State University. She is a member of the Healthcare Financial Managers Association, the Tennessee Society of Certified Public Accountants and the Tennessee Hospital Association.

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FOR IMMEDIATE RELEASE 1/9/14

WELLMONT HEALTH SYSTEM LAUNCHES PROCESS TO ASSESS STRATEGIC OPTIONS FOR FUTURE

KINGSPORT—Wellmont Health System officials have launched a process to evaluate strategic options for the organization’s future, including the possibility of aligning with another health system.

The Wellmont board of directors and leadership team will spend this year engaged in an exploratory process with healthcare experts to evaluate how Wellmont needs to evolve to thrive in the future.

“Because of the mandate of our vision – to deliver the best healthcare anywhere – we strongly believe we must act now to ensure Wellmont evolves with the rapidly changing healthcare industry and continues to provide outstanding care for generations to come,” said Buddy Scott, chairman of Wellmont’s board. “While this is just the beginning of a process and we do not have many specifics today, it is important to be as transparent as possible with all the people who matter to this organization.”

The current climate of the healthcare industry has resulted in a complex set of challenges for hospitals and health systems nationwide.

These organizations must be prepared for increasing levels of information management and technological innovations, quality mandates, a growing demand for primary care services and population health management to advance the wellness of large groups of patients and reduce their need for inpatient hospital care. Providers are also struggling with low patient volumes, reimbursement cuts and possible performance penalties under the Patient Protection and Affordable Care Act.

The challenges are multiplied in Northeast Tennessee and Southwest Virginia because of extremely low Medicare payment rates and the high volume of Medicaid and uninsured populations. Add to this the recent decisions in Virginia and Tennessee not to expand Medicaid coverage. For Wellmont, all of these factors have made it necessary to improve its financial position by millions of dollars during the next several years. In fiscal 2012, Wellmont had a community benefit of \$94 million, which included \$77 million in uncompensated care, as well as free programs and services provided to the community, and cash and in-kind donations to community groups.

Due to these challenges, it is becoming increasingly difficult for healthcare organizations to continue to operate as they have in the past without adapting to the new healthcare landscape. As a result, Wellmont is not alone in pursuing a process such as this. Forward-looking health systems nationally are seeking to fully understand their options. In fact, a recent national survey of healthcare leaders found 75 percent of health systems were already pursuing or were considering aligning their organization with another (*HealthLeaders Media*).

“As stewards of a valued community resource, our Board of Directors and leadership team know it is our responsibility to preserve and advance healthcare in our region,” said Denny DeNarvaez, CEO of Wellmont Health System. “Unlike many health systems, Wellmont is fortunate to be in a position of clinical strength and relative financial stability thanks to the great work of our physicians, co-workers and leadership. The Board and the administration are committed to continue pursuing all internal options to

ensure the financial stability of our health system for the future. However, by proactively embarking on this process, we are taking our future into our own hands and creating a stronger health system for the communities we serve.”

In consultation with national experts, a special committee of the Board has begun a process to assess strategic options for the organization’s future. The guiding principles that will govern this assessment are:

- A strong commitment to Wellmont’s mission, vision, values and operating philosophy
- Significant financial strength to advance medical, technological and organizational innovation and to develop new care models for the good of the patients and communities it serves
- A contribution to long-term economic development, the advancement of healthcare services and employment opportunities in our region
- A strong vision for the importance of philanthropy, good stewardship of donated funds and community benefit
- Optimization of information and medical technology systems
- A robust physician network and physician recruitment capacity and commitment to physician leadership
- An extensive knowledge and resource base to optimize operational, financial, clinical and purchasing systems

“As we explore potential paths, we have the best interest of our hospitals, physicians, patients and the communities we serve in mind, and we will continue to share information as it becomes available,” DeNarvaez said.

“Wellmont is committed to serving patients across Northeast Tennessee and Southwest Virginia and we are motivated by our mission to deliver superior health care with compassion. This will not change with any future direction we consider,” Scott said.

About Wellmont Health System

Wellmont Health System is a leading provider of healthcare services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive healthcare and wellness services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. Wellmont is an operating partner with Adventist Health System at Takoma Regional Hospital in Greeneville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

Media advisory: Denny DeNarvaez and Buddy Scott will be available for interviews at 1:30 p.m. EST at Wellmont Corporate offices at 1905 American Way, Kingsport. For those unable to join in person, you may dial 1-800-617-4268 and key pin code 55500382.

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**WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE
ANNOUNCE PLANS TO PURSUE AN INTEGRATED HEALTH SYSTEM**

New organization would make health care more affordable, redirect resources toward improving health of region

KINGSPORT and JOHNSON CITY, Tenn. – (April 2, 2015) – [Wellmont Health System](#) and [Mountain States Health Alliance](#) have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to address the serious health issues affecting the region and to be among the best in the nation in terms of quality, affordability and patient satisfaction.

In a term sheet signed Wednesday, the boards of directors of both organizations agree to explore combining the assets and operations of Wellmont and Mountain States into a new health system. This decision follows more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option.

“We are excited about this proposed combination that will bring together the capabilities of both Wellmont and Mountain States, combined with a partnership in academics and with our states, to serve the region and result in unprecedented quality and value,” said [Roger Leonard](#), chair of Wellmont’s board. “We are grateful to the thousands of community and business leaders, physicians, employees and patients who have shared their thoughts throughout this process. It was deliberative and methodical, which led us unanimously to the right conclusion.”

“Our board is enthusiastic about this potential partnership,” said [Barbara Allen](#), chair of the board for Mountain States. “We and the leadership of Wellmont all care deeply about the region we serve. We share a passion for improving our region’s health and our region’s economy. We look forward to working closely with the state of Tennessee and the Commonwealth of Virginia, as well as with our payors, to focus on the real drivers of cost reduction and quality-enhancement.”

A new board will be created, which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman.

The president of East Tennessee State University will serve as an ex-officio nonvoting member of the board. The involvement of ETSU will focus on expanding opportunities to compete for research investment in our region, as well as enhancing physician and allied health training for the future.

This new board would direct the proposed health system, which would also have a new name. One leadership team, composed of current executives from both organizations, would lead the combined system. The CEOs of both organizations would share leadership responsibilities.

“Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues – cardiovascular disease, diabetes, addiction and access to mental health services, to name a few – and they must be addressed,” said [Alan Levine](#), president and CEO of Mountain States, who would become executive chairman and president of the combined system. “The cost of this poor health is not sustainable. By integrating, we can refocus our efforts from being measured based on how many patients we can admit to the hospital and how many ways we can duplicate these efforts, to how we measurably improve the health of our region while eliminating unnecessary costs and making health care more affordable. The people of this region deserve nothing less. We intend to demonstrate the merger’s substantial specific potential in these areas.”

An integration council with executive and physician leaders from both systems will be formed to further develop plans for a combined system during the next several months. Those plans will be in the best interest of clinical quality and the patients served, will demonstrate shared values and will honor commitments to employees and physicians.

“Together, we’ll work alongside our employed and independent physicians to shape the future of health care by modeling effective clinical collaboration, building new community health solutions and becoming a national model for rural health care delivery,” said [Bart Hove](#), president and CEO of Wellmont, who would be CEO of the new system. “As one system, our physicians would share best practices, collaborate to benchmark our outcomes against the nation’s best and develop new high-level services closer to home.”

The systems now enter a due diligence period and will work toward developing a definitive agreement. The definitive agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

In Tennessee, the organizations will pursue approval under the state’s COPA (Certificate of Public Advantage) statute. A COPA authorizes the parties to merge and directs the state to actively supervise the new health system to ensure that it continues to benefit the community by providing health care that is affordable, accessible, cost-efficient and high in quality. In Virginia, the health systems will

pursue a process similar to a COPA that is defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

During the next phases of due diligence, integration analysis, planning for potential integration and government approval, both Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

For more information, please visit www.becomingbettertogether.org.

A bondholder conference call will be scheduled in the near future and a notice of this call will be posted on EMMA.

About Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

About Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit www.mountainstateshealth.com.

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Wellmont Health System and Affiliates

**Quarters and Fiscal Years Ended
June 30, 2010 and June 30, 2009**

The following financial statements are unaudited and are subject to change upon completion of the annual independent audit.

Wellmont Health System

Management discussion and analysis for the quarter and fiscal year ended June 30, 2010:

The health system's income from operations was \$1.6 million for the quarter vs. \$9.4 million for the prior year's quarter and \$22.8 million for the fiscal year vs. \$7.0 million for the prior fiscal year. Excluding unusual items such as real estate gains/losses on sale, write off of disputed contract amounts, and the fiscal 2008 and prior year financial statement restatement costs in fiscal 2009, the normalized amounts would be \$2.3 million for the quarter vs. \$12.7 million for the prior year's quarter and \$26.1 million for the fiscal year vs. \$15.7 million for the prior fiscal year.

The annual improvement is a direct result of the operations improvement effort that started in late fiscal 2009. The decrease for the quarter is primarily related to the items discussed in expenses below. Highlights of the quarter and fiscal year operating performance include:

- A large regional cardiology group was acquired in May 2010 and added \$6 million of revenue and expenses for the quarter and fiscal year. The following amounts exclude the impact of this acquisition and the unusual items noted above.
- Total revenue increased 0.1% for the quarter and 1.9% for the fiscal year.
- Inpatient volumes were up slightly from prior year, but surgeries were down, especially the higher margin elective surgeries, which is attributable to the general economic conditions in the area.
- Emergency room visits were down from the prior year, which is partly attributable to the economic conditions but also to significant winter weather transportation problems this year.
- Total expenses increased 6.0% for the quarter and 0.6% for the fiscal year. The increase for the quarter is primarily the result of favorable audit adjustments posted in the last quarter of last year, the depreciation and interest on the main portion of Project Platinum which went into service in January 2010, and increased bad debt expense as a result of economic conditions. The slight increase for the fiscal year is primarily the depreciation and interest on Project Platinum and increased bad debt expense, mostly offset by reduced salaries and benefits from improved labor productivity.
- Hospital labor productivity improved 5.5% for the fiscal year and was flat for the quarter.

The health system's balance sheet and bond covenants highlights include:

- Days cash on hand increased from 133 days at June 30, 2009 to 172 days at March 31, 2010 but decreased slightly to 170 days at June 30, 2010. The small quarterly decrease was driven by \$19 million of EBITDA being exceeded by \$10 million of decreased investment portfolio performance/value, \$6 million of interest, and \$8 million of non-bond capital expenditures. The fiscal year increase was driven by \$87 million of EBITDA and \$23 million of improved investment portfolio performance/value, offset by \$20 million of interest and \$14 million of non-bond capital expenditures. The 170 days is well above the requirement of 100 days.
- Unrestricted net assets decreased by \$14.4 million for the quarter and increased by \$38.6 million for the fiscal year. The quarterly decrease was primarily driven by \$10.4 million of decreased investment portfolio performance/value, \$3.4 million of swap valuation adjustments and \$1.9 million of pension plan adjustments, partially offset by \$1.6 million of income from operations. The fiscal year increase was driven by \$22.8 million income from operations and \$23.3 million of improved investment portfolio performance/value, partially offset by \$2.7 million of swap valuation adjustments and \$3.5 million of pension adjustments.
- Debt service coverage increased from 1.56 at June 30, 2009 to 2.64 at March 31, 2010 but decreased to 2.08 at June 30, 2010. The quarterly decrease was primarily due to a decrease in EBITDA of \$7.0 million, an increase in investment losses of \$5.3 million (due to an impairment of equity investments of \$8.2 million), and a negative \$3.4 million swap valuation adjustment vs. a positive \$6.6 million in the prior year. The fiscal year increase was primarily due to an increase in EBITDA of \$20.6 million less the net negative \$0.9 million change in investment income, swap valuation adjustments, and discontinued operations. The 2.08 is well above the requirements of 1.10 and 1.25.

In June 2010, the health system entered into a definitive agreement to sell its Medical Mall Pharmacy retail pharmacy operations. The losses for Medical Mall Pharmacy and Jenkins Community Hospital (sold in April 2009) are now included in discontinued operations for all periods presented.

Wellmont Health System

The following table shows a comparison of the total volumes for acute discharges, observation patients, surgeries and emergency room visits for the quarters and fiscal years ended June 30, 2010 and June 30, 2009. Note that Jenkins Community Hospital was acquired as of July 16, 2007, but closed and sold as of April 30, 2009, so its volumes are not included.

	<u>FY10</u> <u>QTR 4</u>	<u>FY09</u> <u>QTR 4</u>	<u>FY10</u> <u>YTD</u>	<u>FY09</u> <u>YTD</u>
Hospitals	7	7	7	7
Acute Discharges	10,347	10,270	41,380	42,558
Observation Patients	2,407	2,286	9,530	8,092
Total In/Observation Patients	<u>12,754</u>	<u>12,556</u>	<u>50,910</u>	<u>50,650</u>
Surgeries	6,143	6,394	23,938	25,128
Emergency Room Visits	54,413	56,415	218,007	222,560

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	6/30/10	6/30/09
Assets		
Current assets:		
Cash and cash equivalents	\$ 35,711	\$ 62,791
Assets limited to use that are required for current liabilities	0	2,201
Patient accounts receivable	94,057	98,071
Other receivables	10,919	11,173
Inventories	18,294	17,169
Prepaid expenses & other current assets	7,002	6,040
Total current assets	165,983	197,445
Assets limited as to use, net of current portion	301,807	245,601
Land, buildings and equipment, net	450,205	442,611
Other assets:		
Long-term investments	32,391	30,072
Investments in affiliates	32,019	31,977
Deferred debt expense, net	4,644	4,824
Goodwill, net	9,501	9,508
Other	731	797
	79,286	77,178
Total assets	\$ 997,281	\$ 962,835
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	10,143	13,198
Lines of credit / notes payable	14,000	15,811
Accounts payable and accrued expenses	74,679	77,139
Estimated third-party payor settlements	11,672	12,441
Current portion of other long-term liabilities	7,251	6,352
Total current liabilities	117,745	124,941
Long-term debt, less current portion	467,833	474,608
Other long-term liabilities, less current portion	47,364	38,422
Total liabilities	632,942	637,971
Net assets:		
Unrestricted	358,620	320,030
Temporarily restricted	4,551	3,589
Permanently restricted	1,168	1,245
Total net assets	364,339	324,864
Total liabilities and net assets	\$ 997,281	\$ 962,835

Wellmont Health System and Affiliates
Consolidated Statement of Operations and Change in Net Assets
The quarters and fiscal years ended June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	FY10 QTR 4	FY09 QTR 4	FY10 YTD	FY09 YTD
Revenue:				
Net patient revenue	183,178	178,393	715,057	699,303
Other revenue	8,028	7,478	31,472	27,842
Total revenue	<u>191,206</u>	<u>185,871</u>	<u>746,529</u>	<u>727,145</u>
Expenses:				
Salaries and benefits	82,497	77,827	310,667	323,801
Medical supplies and drugs	38,197	35,347	150,143	141,044
Purchased services	20,225	21,005	74,922	81,031
Interest	5,675	4,548	20,110	16,013
Provision for bad debts	13,167	12,126	57,431	52,649
Depreciation and amortization	11,512	11,783	43,711	42,957
Other	18,335	13,819	66,735	62,603
Total expenses	<u>189,608</u>	<u>176,455</u>	<u>723,719</u>	<u>720,098</u>
Income from operations	<u>\$1,598</u>	<u>\$9,416</u>	<u>\$22,810</u>	<u>\$7,047</u>
Nonoperating gains (losses):				
Investment income	(8,907)	(3,557)	(1,827)	4,181
Derivative valuation adjustments	(3,402)	6,562	(2,693)	(5,747)
Other, net	(1,060)	(247)	(1,870)	(625)
Nonoperating (losses) gains, net	<u>(13,369)</u>	<u>2,758</u>	<u>(6,390)</u>	<u>(2,191)</u>
Revenues and gains in excess of expenses and losses before discontinued operations	(\$11,771)	\$12,174	\$16,420	\$4,856
Discontinued operations	(1)	(2,317)	(1,109)	(4,456)
Revenues and gains in excess of expenses and losses	<u>(\$11,772)</u>	<u>\$9,857</u>	<u>\$15,311</u>	<u>\$400</u>
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(1,452)	26,136	25,151	(60,663)
Net assets released from restrictions for additions to land, buildings, and equipment	750	1,102	1,556	2,758
Transfer to/from permanently restricted net assets	0	0	79	0
Change in the funded status of benefit plans and other	(1,912)	(13,068)	(3,507)	(13,568)
Increase (decrease) in unrestricted net assets	<u>(14,386)</u>	<u>24,027</u>	<u>38,590</u>	<u>(71,073)</u>
Changes in temporarily restricted net assets:				
Contributions	1,189	(1)	2,934	1,944
Net assets released from temporary restrictions	(1,337)	(1,209)	(1,972)	(3,154)
Increase (decrease) in temporarily restricted net assets	<u>(148)</u>	<u>(1,210)</u>	<u>962</u>	<u>(1,210)</u>
Changes in permanently restricted net assets:				
Transfer to/from unrestricted net assets	0	0	(79)	0
Permanently restricted contributions and investment income	0	0	2	645
Increase (decrease) in permanently restricted net assets	<u>0</u>	<u>0</u>	<u>(77)</u>	<u>645</u>
Change in net assets	<u>(14,534)</u>	<u>22,817</u>	<u>39,475</u>	<u>(71,638)</u>
Net assets, beginning of period	378,873	302,048	324,864	396,501
Net assets, end of period	<u>364,339</u>	<u>324,864</u>	<u>364,339</u>	<u>324,863</u>

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2010 and June 30, 2009
(Dollars in Thousands)(Unaudited)

	FY10 YTD	FY09 YTD
Cash flows from operating activities:		
Change in net assets	\$ 39,475	\$ (71,638)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	43,711	42,988
Net realized and unrealized (gains) losses on investments	(25,151)	60,663
Unrealized (gain) loss on swaps	2,693	(5,747)
(Gain) loss on sale of fixed assets	1,282	660
Increase (decrease) in cash due to changes in:		
Accounts receivable	4,014	11,444
Inventories	(1,125)	(353)
Prepaid expenses and other current assets	(708)	1,508
Accounts payable and accrued expenses	11,831	41,056
Net (increase) decrease in other assets	(76,244)	(907)
Net cash provided by operating activities	(222)	79,674
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(52,588)	(80,043)
Transfer to/from bond funds	38,575	55,207
Net cash used in investing activities	(14,013)	(24,836)
Cash flows from financing activities:		
Proceeds from note payable	14,000	0
Repayment of line of credit	(14,000)	0
Repayment of long term debt	(12,845)	(7,736)
Net cash used in financing activities	(12,845)	(7,736)
Increase (decrease) in cash and cash equivalents	(27,080)	47,102
Cash and cash equivalents, beginning	62,791	15,689
Cash and cash equivalents, ending	\$ 35,711	\$ 62,791

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
June 30, 2011 and June 30, 2010**

**Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2011 and June 30, 2010**

The following financial statements are unaudited and are subject to
change upon completion of the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2011

Volumes:

Volumes were generally up from the same quarter last year. Inpatient and observation volumes grew by 865 patients or 6.8% over the same quarter last year, with inpatients up 1.0% and observation patients up more than 30%, primarily due to a change in post-surgical patient classification and partially due to continued managed care payor changes. Emergency room visits were 0.7% over the same quarter last year. Other outpatient volume was 5.7% over the same quarter last year. Surgical volumes were down 3.7% from the same quarter last year in both the inpatient and outpatient settings. Deliveries were down 12.1% due to obstetrician turnover at Holston Valley Medical Center and Lonesome Pine Hospital. Our physician office visits were up 9.3% primarily due to the acquisitions of a large cardiology practice in May 2010 and a pulmonology practice in January 2011.

Comparing the last fiscal year to the current fiscal year, we experienced a positive 3.9% growth in our inpatient and observation volumes. Our emergency room visits are lagging last year by 1.9% primarily due to utilization trends. Other outpatient volumes were 3.0% over last year. We had surgical growth of 2.3% entirely due to outpatient volumes. Deliveries were down 8.1% due to obstetrician turnover at Holston Valley Medical Center and Lonesome Pine Hospital. Physician office visits were up 20.4% primarily due to the acquisitions noted above.

Length of stay for the quarter and year-to-date is trending slightly higher as a result of moving the shorter length of stay cases to the outpatient arena. Our case mix indices are trending slightly lower than last year as a result of the mix between medical and surgical cases.

Statement of Operations:

The changes that follow exclude the impact of the acquisitions of the cardiology practice in May 2010 and the pulmonology practice in January 2011, and the TennCare fee assessment which was new for fiscal 2011. In total, these items added \$9.8 million of net patient revenue, \$0.8 million of other revenue, and \$11.1 million of expenses for the quarter over the prior year and \$51.3 million of net patient revenue, \$4.2 million of other revenue, and \$58.5 million of expenses for the fiscal year over the prior year.

Quarter ended June 30, 2011 versus quarter ended June 30, 2010:

Net patient revenue has grown \$10.1 million and bad debt expense increased \$3.7 million over the same quarter last year, so the net change of these two lines is an increase of \$6.4 million or 3.9% (the classification of bad debt and charity was refined considerably in the last quarter of fiscal 2011). Other revenue decreased as a result of lower performance related to the Takoma and imaging joint ventures.

Salaries and benefits have increased by \$0.7 million or 0.9% driven primarily by the higher volumes. Supplies have increased by \$0.7 million or 1.8% driven by the higher volumes and higher drug costs, particularly in oncology. Interest decreased \$0.9 million due to the reduction

in notes payable and letter of credit fees. Other expenses decreased \$1.0 million as the prior year included acquisition and other one time expenses.

Fiscal 2011 versus fiscal 2010:

Net patient revenue has grown \$23.2 million and bad debt expense increased \$1.8 million over the prior fiscal year, so the net change of these two lines is an increase of \$21.4 million or 3.3%. Other revenue decreased as a result of lower performance related to the Takoma, imaging and lab joint ventures.

Salaries and benefits has increased by \$6.2 million or 2.0% driven by the higher volumes, an increase in FTEs for patient care as well as to support computerized order entry and electronic health record system build and implementation. Supplies have increased by \$8.3 million or 5.5% driven by the higher volumes and higher drug costs, particularly in oncology. Purchased services increased by \$3.5 million as a result of physician fees at the hospitals, a new urgent care operation, and physician practice management and system implementation costs. Interest and depreciation increases are related to the completion of Project Platinum.

For the fiscal year, growth in expenses has out-stripped the growth in revenues resulting in a 2.2% operating margin versus 3.2% for the prior fiscal year. However, the strong volume in the last quarter produced an operating margin of 3.4% which was more than the prior year's last quarter of 0.9%.

Investments are performing well with the rebound in the market while the mark-to-market on our derivatives is not as volatile as last year, both for the quarter and fiscal year.

Balance Sheet:

In May 2011, the Series 2006A bonds (par \$76,595,000) were refunded with the Series 2011 bonds (par \$76,165,000). The total return swap associated with the Series 2006A bonds was terminated and a new total return swap associated with the Series 2011 bonds was initiated with a different counterparty. Also in May 2011, the letter of credit provider on the Series 2005 bonds was replaced with a different letter of credit provider. In November 2010, a \$30 million bank qualified loan was issued with a cumulative drawdown of \$15 million at June 30, 2011. This partially offset the use of \$13 million in the first quarter to pay off the taxable bond issue. \$7 million of the short term note payable was repaid in January 2011 and the remaining \$7 million was repaid in June 2011. The purchase of the pulmonary practice that operated a free standing ambulatory surgery center and two sleep laboratories resulted in the increase in goodwill. Net patient receivables grew as a result of our physician practice acquisitions and billing system conversion. Our debt to capitalization position and debt service coverage have both improved for the quarter and fiscal year. Days cash on hand has increased for the quarter and decreased slightly for the fiscal year due to the acquisitions and debt changes.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for the quarters and twelve months ended June 30, 2011 and June 30, 2010.

	FY11 QTR 4	FY10 QTR 4	FY11 YTD	FY10 YTD
Hospital Statistics:				
Beds in Service	781	781	781	781
Acute Discharges	10,450	10,347	42,070	41,380
Observation Patients	3,169	2,407	10,841	9,530
Patients in Bed	13,619	12,754	52,911	50,910
Patient Days	45,260	43,505	183,934	177,715
Average Length of Stay (Days)	4.33	4.20	4.37	4.29
Daily Census including Observations	532	505	534	513
Percent Occupancy	68.14%	64.60%	68.33%	65.69%
Emergency Room Visits	53,144	52,761	208,252	212,383
Outpatient Registrations excluding ER	58,227	55,111	225,035	218,400
Deliveries	494	562	2,056	2,238
Surgical Cases:				
Inpatient	2,431	2,579	10,054	10,372
Outpatient	6,436	6,631	26,284	25,160
Physician Office Visits:	79,313	72,585	310,896	258,263

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2011 and June 30, 2010

	FY11 YTD	FY10 YTD
Medicare	32.7%	32.5%
Medicare Managed Care	19.8%	18.4%
Medicaid	12.8%	13.5%
Managed Care	25.1%	25.0%
Self	6.5%	6.5%
Other	3.1%	4.1%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	As of 6/30/11	As of 6/30/10
Assets		
Current assets:		
Cash and cash equivalents	\$ 36,558	\$ 35,711
Assets limited to use that are required for current liabilities	1,903	1,815
Patient accounts receivable	108,565	94,057
Other receivables	9,904	10,919
Inventories	17,830	18,294
Prepaid expenses & other current assets	7,162	7,003
Total current assets	181,922	167,799
Assets limited as to use, net of current portion	319,387	301,807
Land, buildings and equipment, net	447,634	450,205
Other assets:		
Long-term investments	36,437	32,391
Investments in affiliates	31,177	32,019
Deferred debt expense, net	5,847	4,644
Goodwill, net	16,721	9,501
Other	1,875	730
	92,057	79,285
Total assets	\$ 1,041,000	\$ 999,096
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	9,262	11,958
Short term notes payable	0	14,000
Accounts payable and accrued expenses	68,952	74,679
Estimated third-party payor settlements	16,533	11,672
Current portion of other long-term liabilities	8,527	7,251
Total current liabilities	103,274	119,560
Long-term debt, less current portion	453,958	467,833
Other long-term liabilities, less current portion (1)	42,006	44,977
Total liabilities	599,238	632,370
Net assets:		
Unrestricted	434,662	358,620
Temporarily restricted	3,570	4,551
Permanently restricted	1,174	1,168
Noncontrolling interests (1)	2,356	2,387
Total net assets	441,762	366,726
Commitments and contingencies		
Total liabilities and net assets	\$ 1,041,000	\$ 999,096

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance.

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	FY11 QTR 4	FY10 QTR 4	FY11 YTD	FY10 YTD
Revenue:				
Net patient revenue	\$197,557	\$177,644	\$767,450	\$692,920
Other revenue	7,002	7,423	29,799	29,237
Total revenue	<u>204,559</u>	<u>185,067</u>	<u>797,249</u>	<u>722,157</u>
Expenses:				
Salaries and benefits	88,283	82,498	347,185	310,667
Medical supplies and drugs	39,289	38,197	160,565	150,143
Purchased services	20,547	20,226	80,348	74,922
Interest	4,805	5,674	20,750	20,110
Provision for bad debts	11,372	7,632	37,858	35,293
Depreciation and amortization	11,392	11,512	46,059	43,711
Other	21,946	17,730	87,319	64,499
Total expenses	<u>197,634</u>	<u>183,469</u>	<u>780,084</u>	<u>699,345</u>
Income from operations	<u>6,925</u>	<u>1,598</u>	<u>17,165</u>	<u>22,812</u>
Nonoperating gains (losses)(1):				
Investment income	2,059	(6,068)	10,383	1,012
Derivative valuation adjustments	(1,595)	(3,401)	1,355	(2,693)
Gain on bond dissolution	1,041	0	1,041	0
Other, net	0	(809)	(610)	(805)
Nonoperating (losses) gains, net	<u>1,505</u>	<u>(10,278)</u>	<u>12,169</u>	<u>(2,486)</u>
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	<u>8,430</u>	<u>(8,680)</u>	<u>29,334</u>	<u>20,326</u>
Discontinued operations	82	(1)	44	(1,109)
Revenues and gains in excess of expenses and losses	<u>\$8,512</u>	<u>(\$8,681)</u>	<u>\$29,378</u>	<u>\$19,217</u>
Income attributable to noncontrolling interests (1)	<u>(225)</u>	<u>(271)</u>	<u>(1,238)</u>	<u>(1,065)</u>
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	<u>8,287</u>	<u>(8,952)</u>	<u>28,140</u>	<u>18,152</u>
Other changes in unrestricted net assets (1):				
Change in net unrealized gains (losses) on investments	2,214	(4,291)	42,186	22,312
Net assets released from restrictions for additions to land, building and equipment	1,563	750	2,852	1,555
Transfer to/from Temporarily restricted net assets	(18)	0	(18)	0
Transfer to/from permanently restricted net assets	0	0	0	79
Change in the funded status of benefit plans and other	2,777	(1,914)	2,882	(3,508)
Increase (decrease) in unrestricted net assets	<u>14,823</u>	<u>(14,407)</u>	<u>76,042</u>	<u>38,590</u>
Changes in temporarily restricted net assets:				
Contributions	419	1,189	2,549	2,934
Transfer to/from unrestricted net assets	18	0	18	0
Net assets released from temporary restrictions	(1,684)	(1,337)	(3,548)	(1,972)
Increase (decrease) in temporarily restricted net assets	<u>(1,247)</u>	<u>(148)</u>	<u>(981)</u>	<u>962</u>
Changes in permanently restricted net assets:				
Transfer to/from unrestricted net assets	0	0	0	(79)
Permanently restricted contributions and investment income	4	0	6	2
Increase (decrease) in permanently restricted net assets	<u>4</u>	<u>0</u>	<u>6</u>	<u>(77)</u>
Changes in noncontrolling interests (1):				
Income attributable to noncontrolling interests	225	271	1,238	1,065
Distributions to noncontrolling interests	(154)	0	(1,178)	(711)
Changes in noncontrolling percentages	0	0	(91)	(21)
Increase (decrease) in noncontrolling interests	<u>71</u>	<u>271</u>	<u>(31)</u>	<u>333</u>
Change in net assets (1)	<u>13,651</u>	<u>(14,284)</u>	<u>75,036</u>	<u>39,808</u>
Net assets, beginning of period (1)	428,111	381,010	366,726	326,918
Net assets, end of period (1)	<u>\$441,762</u>	<u>\$366,726</u>	<u>\$441,762</u>	<u>\$366,726</u>

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance.

Certain 2010 amounts have been reclassified to conform to the 2011 presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2011 and June 30, 2010
(Dollars in Thousands)(Unaudited)

	FY11	FY10
Cash flows from operating activities:		
Change in net assets (1)	\$ 75,036	\$ 39,808
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	46,059	43,711
Net realized and unrealized (gains) losses on investments	(52,569)	(23,324)
Derivative valuation adjustments	(1,355)	2,693
Gain on bond dissolution	(1,041)	0
(Gain) loss on sale of fixed assets	(162)	1,282
Increase (decrease) in cash due to changes in:		
Accounts Receivable	(14,508)	4,014
Inventories	464	(1,125)
Prepaid expenses and other current assets	854	(708)
Accounts payable and accrued expenses	(1,774)	11,831
Net decrease (increase) in other assets (1)	(4,990)	(2,531)
Net cash provided by operating activities	46,014	75,651
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(43,326)	(51,327)
Transfer to/from Bond Funds	8,332	38,575
Transfer to/from Board Designated Funds	26,884	(71,773)
Acquisitions	(7,056)	(2,421)
Net cash used in investing activities	(15,166)	(86,946)
Cash flows from financing activities:		
Proceeds from long term debt	91,133	0
Proceeds from note payable	0	14,000
Repayment of line of credit	0	(15,800)
Repayment of note payable	(14,000)	0
Repayment of long term debt	(107,135)	(12,083)
Net cash used in financing activities	(30,002)	(13,883)
Increase (decrease) in cash and cash equivalents	846	(25,178)
Cash and cash equivalents, beginning	35,711	60,889
Cash and cash equivalents, ending	\$ 36,558	\$ 35,711

(1) Reflects change from "minority interests" to "noncontrolling interests" from the adoption of authoritative guidance.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

	6/30/11	6/30/10
<u>Capitalization</u>		
Current portion of long-term debt	\$ 9,262	\$ 11,958
Short-term notes payable	-	14,000
Long-term debt, less current portion	A 453,958	467,833
Total debt	<u>463,220</u>	<u>493,791</u>
Unrestricted net assets	B 434,662	358,620
Other net assets	7,100	8,106
Total net assets	<u>441,762</u>	<u>366,726</u>
Long-term debt plus Unrestricted net assets	A+B <u>\$888,620</u>	<u>\$826,453</u>
Long-term debt to Capitalization	A/(A+B) 0.511	0.566
<u>Debt Service Coverage</u>		
Revenue and gains in excess of expenses and losses (12 months)	\$ 29,378	\$ 19,217
Add back:		
Depreciation and amortization (12 months)	46,059	43,711
Interest expense (12 months)	20,750	20,110
(Gain) Loss from discontinued operations (12 months)	(44)	1,109
Total income available for debt service per Master Trust Indenture	C <u>96,143</u>	<u>84,147</u>
Maximum annual debt service	D <u>\$ 35,157</u>	<u>\$ 38,050</u>
Debt Service Coverage Ratio per Master Trust Indenture	C/D 2.73	2.21
<u>Days Cash on Hand</u>		
Unrestricted cash	\$ 36,558	\$ 35,711
Unrestricted investments:		
Capital improvements	273,886	247,674
Long-term investments	36,437	32,391
Less illiquid investments	(38,349)	(35,003)
	E <u>308,532</u>	<u>280,773</u>
Operating expenses (12 months)	780,084	699,345
Less depreciation and amortization	(46,059)	(43,711)
Total cash expenses	<u>734,025</u>	<u>655,634</u>
Number of days in the period	365	365
Daily cash operating expenses	F \$ 2,011	\$ 1,796
Days cash on hand	E/F <u>153.42</u>	<u>156.31</u>

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
June 30, 2012 and June 30, 2011**

**Consolidated Statements of Operations and Changes in Net Assets
for the Quarters and Fiscal Years ended
June 30, 2012 and June 30, 2011**

The following financial statements are unaudited but agree to
the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2012

Volumes:

Volumes were mixed compared to the same quarter last year. Inpatients were down 6.3% and observation patients were up 5.5%, due to continued managed care payor changes. Emergency room visits were down 3.6% and other outpatient volume was up 2.3%. Surgical volumes were up 4.2% and deliveries were up 6.7%. Our physician office visits were up 20.1% primarily due to the acquisitions of a cardiology practice in October 2011 and a multispecialty practice in January 2012.

Volumes were also mixed compared to the prior fiscal year. Inpatients were down 4.6% and observation patients were up 26.1%, due to a change in post-surgical patient classification and to continued managed care payor changes. Emergency room visits were the same as last year and other hospital outpatient volumes were up 5.1%. Surgical volumes were the same as last year and deliveries were down 1.7%. Physician office visits were up 15.9% primarily due to the acquisitions noted above.

Length of stay for the quarter and year-to-date is trending slightly lower due to a focus on case management. The case mix indices are the same as last year.

Statement of Operations:

We adopted Accounting Standards Update 2011-07 regarding the presentation of patient service revenue and bad debts this fiscal year on a retroactive basis. There is no impact on income from operations and simply moves the provision for bad debts from expenses to revenue.

Quarter ended June 30, 2012 versus quarter ended June 30, 2011:

Net patient service revenue increased \$2.3 million or 1.2% from the same quarter last year. Other revenue increased \$14.4 million primarily as a result of \$12.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter by Wellmont Health System hospitals and physician practices and \$1.4 million earned by Takoma Regional Hospital (of which Wellmont Health System owns 60% so recorded \$0.8 million)(also see the fiscal year discussion below).

Salaries and benefits increased \$8.3 million or 9.5%, driven by the physician practice growth and acquisitions. Hospital productivity improved, as hours per adjusted discharge decreased 1.7%. Supplies increased \$1.7 million or 4.4% primarily due to growth in infusion volumes, particularly in oncology.

Income from operations of \$11.6 million exceeded the \$6.9 million for the same quarter last year, primarily due to the Meaningful Use amounts.

Fiscal 2012 versus fiscal 2011:

Net patient revenue increased \$12.2 million or 1.7% over the prior fiscal year. Other revenue increased \$18.1 million primarily as a result of the Electronic Health Record Meaningful Use amounts earned during the year, with \$13.1 million earned by Wellmont Health System hospitals and physician practices and \$3.2 million earned by Takoma Regional Hospital (of which Wellmont Health System owns 60% so recorded \$1.9 million). However, significant costs have been incurred to purchase and implement the systems necessary to achieve Meaningful Use. This includes approximately \$13 million of capital costs which resulted in approximately \$5 million of annual depreciation and maintenance costs plus \$4.6 million of staff costs to implement the systems.

Salaries and benefits increased \$21.6 million or 6.2% primarily due to the physician practice acquisitions (\$9.5 million) and the \$4.6 million to implement the systems. Hospital productivity improved, as hours per adjusted discharge decreased 6.7%. Supplies increased \$3.8 million or 2.4% primarily due to growth in infusion volumes, particularly in oncology.

Income from operations of \$22.3 million exceeded the prior fiscal year of \$17.2 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$32.9 million exceeded the prior fiscal year of \$28.2 million.

Balance Sheet:

Days cash on hand increased as a result of the strong operating performance and investment returns. Net patient accounts receivable increased primarily as a result of the physician practice acquisitions. Other receivables increased due to the accrual of the Meaningful Use amounts earned at June 30, 2012. Accounts payable and accrued expenses increased primarily due to having a pay period end on June 30, 2012. Net assets was negatively impacted by an increase in pension liabilities as a result of the continued low interest rate environment. Debt to capitalization and debt service coverage ratios both improved as a result of the strong operating performance.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and specialty care facilities owned and operated by Wellmont for the quarters and fiscal years ended June 30, 2012 and June 30, 2011.

	<u>FY12</u> <u>QTR 4</u>	<u>FY11</u> <u>QTR 4</u>	<u>FY12</u> <u>YTD</u>	<u>FY11</u> <u>YTD</u>
Hospital Statistics:				
Acute Discharges	9,790	10,450	40,121	42,070
Observation Patients	3,344	3,169	13,669	10,841
Patients in Bed	<u>13,134</u>	<u>13,619</u>	<u>53,790</u>	<u>52,911</u>
Patient Days	41,495	45,260	173,533	183,934
Average Length of Stay (Days)	4.24	4.33	4.33	4.37
Daily Census including Observations	493	532	511	532
Emergency Room Visits	51,216	53,144	208,013	208,252
Outpatient Registrations excluding ER Deliveries	59,575	58,227	236,437	225,035
	527	494	2,021	2,056
Surgical Cases:				
Inpatient	2,401	2,431	9,418	10,054
Outpatient	6,840	6,436	26,839	26,284
Total Surgical Cases	<u>9,241</u>	<u>8,867</u>	<u>36,257</u>	<u>36,338</u>
Physician Office Visits	95,271	79,313	359,942	310,578

The following table shows the percentage of gross patient service revenue by payor for the fiscal year ended June 30, 2012 and the fiscal year ended June 30, 2011.

	<u>FY12</u> <u>All Year</u>	<u>FY11</u> <u>All Year</u>
Medicare	32.1%	32.7%
Medicare Managed Care	20.8%	19.8%
Medicaid	11.4%	12.7%
Managed Care	25.3%	25.2%
Self	7.7%	6.5%
Other	2.7%	3.1%
	<u>100.0%</u>	<u>100.0%</u>

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2012 and June 30, 2011
(Dollars in Thousands)(Unaudited)

	<u>As of</u> <u>6/30/12</u>	<u>As of</u> <u>6/30/11</u>
Assets		
Current assets:		
Cash and cash equivalents	\$ 44,930	\$ 36,558
Assets limited to use that are required for current liabilities	4,372	1,902
Patient accounts receivable	108,265	101,565
Other receivables	23,805	9,904
Inventories	17,862	17,830
Prepaid expenses & other current assets	7,462	7,163
Total current assets	206,696	174,922
Assets limited as to use, net of current portion	339,030	319,387
Land, buildings and equipment, net	458,048	454,937
Other assets:		
Long-term investments	36,633	36,437
Investments in affiliates	32,646	31,177
Deferred debt expense, net	5,419	5,847
Goodwill, net	17,090	16,721
Other	651	1,875
	92,439	92,057
Total assets	\$ 1,096,213	\$ 1,041,303
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	\$ 11,913	\$ 9,273
Accounts payable and accrued expenses	81,243	70,943
Estimated third-party payor settlements	15,535	9,533
Current portion of other long-term liabilities	5,782	8,527
Total current liabilities	114,473	98,276
Long-term debt, less current portion	459,654	458,882
Other long-term liabilities, less current portion	54,060	42,384
Total liabilities	628,187	599,542
Net assets:		
Unrestricted	458,218	434,661
Temporarily restricted	5,739	3,570
Permanently restricted	1,304	1,174
Noncontrolling interests	2,765	2,356
Total net assets	468,026	441,761
Commitments and contingencies		
Total liabilities and net assets	\$ 1,096,213	\$ 1,041,303

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2012 and June 30, 2011
(Dollars in Thousands)(Unaudited)

	FY12 QTR 4	FY11 QTR 4	FY12 YTD	FY11 YTD
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	\$209,950	\$197,557	\$813,229	767,450
Provision for bad debts	(21,462)	(11,372)	(71,407)	(37,858)
Net patient service revenue less provision for bad debts	188,488	186,185	741,822	729,592
Other revenue	21,352	7,002	47,904	29,799
Total revenue	209,840	193,187	789,726	759,391
Expenses:				
Salaries and benefits	96,632	88,283	368,772	347,185
Medical supplies and drugs	41,017	39,289	164,397	160,565
Purchased services	21,128	20,547	79,509	80,348
Interest	5,428	4,805	21,677	20,750
Depreciation and amortization	12,290	11,392	46,403	46,059
Other	21,777	21,946	86,645	87,319
Total expenses	198,272	186,262	767,403	742,226
Income from operations	11,568	6,925	22,323	17,165
Nonoperating gains (losses):				
Investment income	6,631	2,058	17,272	10,383
Derivative valuation adjustments	5,305	(1,594)	1,807	1,355
Gain on bond dissolution	0	1,042	0	1,042
Other, net	0	0	0	(519)
Nonoperating gains (losses), net	11,936	1,506	19,079	12,261
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	23,504	8,431	41,402	29,426
Discontinued operations	92	82	88	44
Revenues and gains in excess of expenses and losses	23,596	8,513	41,490	29,470
Income attributable to noncontrolling interests	(504)	(225)	(1,670)	(1,238)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	23,092	8,288	39,820	28,232
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(9,042)	2,214	(9,534)	42,186
Net assets released from restrictions for additions to land, buildings, and equipment	2,801	1,563	3,766	2,852
Transfer to/from Temporarily restricted net assets	0	(18)	0	(18)
Change in the funded status of benefit plans and other	(10,495)	2,776	(10,495)	2,789
Increase (decrease) in unrestricted net assets	6,356	14,823	23,557	76,041
Changes in temporarily restricted net assets:				
Contributions	431	419	6,661	2,548
Transfer to/from unrestricted net assets	0	18	0	18
Net assets released from temporary restrictions	(2,988)	(1,684)	(4,492)	(3,547)
Increase (decrease) in temporarily restricted net assets	(2,557)	(1,247)	2,169	(981)
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	128	4	130	6
Increase (decrease) in permanently restricted net assets	128	4	130	6
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	504	225	1,670	1,238
Distributions to noncontrolling interests	(369)	(155)	(1,261)	(1,178)
Changes in noncontrolling percentages				(92)
Increase (decrease) in noncontrolling interests	135	70	409	(32)
Change in net assets	4,062	13,650	26,265	75,034
Net assets, beginning of period	463,964	428,111	441,761	366,727
Net assets, end of period	\$468,026	\$441,761	\$468,026	\$441,761

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

		6/30/12	6/30/11
<u>Capitalization</u>			
Current portion of long-term debt		\$ 11,913	\$ 9,273
Short-term notes payable			-
Long-term debt, less current portion	A	459,654	459,260
Total debt		<u>471,567</u>	<u>468,533</u>
Unrestricted net assets	B	458,218	434,661
Other net assets		9,808	7,100
Total net assets		<u>468,026</u>	<u>441,761</u>
Long-term debt plus Unrestricted net assets	A+B	<u>\$917,872</u>	<u>\$ 893,921</u>
Long-term debt to Capitalization	A/(A+B)	<u>0.501</u>	<u>0.514</u>
<u>Debt Service Coverage</u>			
Revenue and gains in excess of expenses and losses (12 months)		\$ 39,820	\$ 28,232
Add back:			
Depreciation and amortization (12 months)		46,403	46,059
Interest expense (12 months)		21,677	20,750
(Gain) loss from discontinued operations (12 months)		(88)	(44)
Total income available for debt service per Master Trust Indenture	C	<u>107,812</u>	<u>94,997</u>
Maximum annual debt service	D	<u>\$ 35,157</u>	<u>\$ 35,157</u>
Debt Service Coverage Ratio per Master Trust Indenture	C/D	<u>3.07</u>	<u>2.70</u>
<u>Days Cash on Hand</u>			
Unrestricted cash		\$ 44,930	\$ 36,558
Unrestricted investments:			
Capital improvements		297,981	273,886
Long-term investments		36,633	36,437
Less illiquid investments		(38,885)	(38,349)
	E	<u>340,659</u>	<u>308,532</u>
Operating expenses (12 months)		767,403	742,226
Less depreciation and amortization		(46,403)	(46,059)
Total cash expenses		<u>721,000</u>	<u>696,167</u>
Number of days in the period		366	365
Daily cash operating expenses	F	\$ 1,970	\$ 1,907
Days cash on hand	E/F	<u>172.9</u>	<u>161.8</u>

Certain FY2011 amounts have been reclassified to conform to the FY2012 presentation.

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
June 30, 2013 and June 30, 2012**

**Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2013 and June 30, 2012**

The following financial statements are unaudited but agree to
the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2013

Volumes:

Quarter:

Volumes were mixed compared to the same quarter last year. Inpatients were down 948 or 9.7% and observation patients were up 638 or 19.1% (so total "patients in a bed" was down 310 or 2.4%) primarily due to reduced inpatient utilization from the implementation of the accountable care organizations in our area. Emergency room visits were down 10.8% due to Wellmont now having three urgent care centers as a more cost effective and patient friendly alternative, other outpatient volume was up 1.2%, and surgeries were down 3.5%. Deliveries were up 6.3% as a result of new physicians and physician office visits were up 14.0% primarily due to the urgent care centers.

Fiscal Year:

Volumes were also mixed compared to the prior fiscal year to date. Inpatients were down 2,323 or 5.8% and observation patients were up 72 or 0.5% (so total "patients in a bed" was down 2,251 or 4.2%) primarily due to reduced inpatient utilization from the implementation of the accountable care organizations in our area. Emergency room visits were down 6.7% due to Wellmont now having three urgent care centers as a more cost effective and patient friendly alternative, other outpatient volume was up 0.5%, and surgeries were down 2.6%. Deliveries were up 14.3% as a result of new physicians and physician office visits were up 17.2% primarily due to the urgent care centers and the acquisitions of a cardiology practice in October 2011 and a multispecialty practice in January 2012.

Statement of Operations:

Quarter ended June 30, 2013 versus quarter ended June 30, 2012:

Net patient service revenue increased \$2.5 million or 1.3% from the same quarter last year. Other revenue decreased \$11.4 million primarily as a result of \$2.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter being \$10.0 million below prior year amounts of \$12.8 million due to the timing of each facility's implementation.

Salaries and benefits increased \$0.4 million or 0.4%. Hospital productivity remained flat as compared to the same quarter last year. Supplies increased \$2.2 million or 5.4% due to a higher volume of orthopedic/spinal implant surgeries and robotic surgeries. Purchased services decreased \$1.1 million or 5.2% due to changes in physician agreements. Interest expense decreased \$0.3 million or 6.0%. Depreciation increased \$0.5 million or 4.1%.

Income from operations of \$1.9 million was below the same quarter last year by \$9.6 million due to the \$10.0 million decrease in Meaningful Use amounts earned during each quarter. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$3.2 million was below the same quarter last year by \$19.9 million

due to the \$9.6 million decrease in income from operations, a \$3.8 million decrease in investment income, a \$4.4 million decrease in derivative valuation adjustments, and a \$2.4 million increase in the loss from discontinued operations (due to the closure of certain sleep lab operations in this quarter).

Fiscal Year:

Net patient service revenue increased \$14.0 million or 1.9% from the prior fiscal year. Other revenue decreased \$4.2 million primarily as a result of lower volumes in subsidiaries providing services to hospitals such as laundry and blood services (\$1.5 million) and lower earnings in an imaging joint venture (\$1.3 million). Note that there was \$13.7 million of Electronic Health Record Meaningful Use amounts earned this year which is essentially the same as the prior year amounts of \$13.2 million.

Salaries and benefits increased \$12.9 million or 3.5%, primarily driven by the physician practice growth and acquisitions and an increase in healthcare benefit costs due to increasing enrollment. Hospital productivity remained flat as compared to the prior fiscal year. Supplies decreased \$0.4 million or 0.3%. Purchased services increased \$1.4 million or 1.8% from several factors, the largest of which are from changes in the hospital physician services such as anesthesia (which was then decreased in the last quarter) and emergency medicine. Interest expense was essentially unchanged. Depreciation increased \$5.0 million or 10.7% primarily for systems necessary to achieve Meaningful Use.

Income from operations of \$12.9 million was below the prior fiscal year by \$9.5 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$31.4 million was below the prior fiscal year by \$8.4 million due to the \$9.5 million decrease in income from operations and a \$2.1 million increase in the loss from discontinued operations (due to the closure of certain sleep lab operations), offset by a \$2.2 million increase in investment income and a \$0.5 million increase in derivative valuation adjustments.

Balance Sheet:

Days cash on hand increased primarily as a result of strong investment valuations, receipt of Meaningful Use funds, and net borrowings. The net borrowings consist of (a) \$12.5 million taxable bank loan for the Epic implementation (fully drawn), (b) \$42.5 million of tax exempt lease for the Epic implementation (\$16.2 million drawn thus far), (c) \$10 million lease line of credit (\$5.2 million drawn thus far), less (d) regular debt and capital lease payments of \$14.5 million. Other receivables decreased due to the receipt of the Meaningful Use amounts earned and accrued at June 30, 2012. The debt to capitalization ratio improved slightly due to the increase in net assets outweighing the impact of the net borrowings. The debt service coverage ratio dropped slightly due to the net borrowings.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics of the inpatient and other entities owned and operated by Wellmont for the quarters and fiscal years ended June 30, 2013 and June 30, 2012.

	FY13 QTR 4	FY12 QTR 4	FY13 YTD	FY12 YTD
Hospital Statistics:				
Acute Discharges	8,842	9,790	37,798	40,121
Observation Patients	3,982	3,344	13,741	13,669
Patients in Bed	12,824	13,134	51,539	53,790
Patient Days	36,499	41,495	162,459	173,533
Average Length of Stay (Days)	4.13	4.24	4.30	4.33
Daily Census including Observations	445	493	483	511
Emergency Room Visits	43,091	48,297	183,378	196,521
Outpatient Registrations excluding Observations, ER and Surgeries	53,379	52,761	210,044	209,024
Deliveries	560	527	2,309	2,021
Surgical Cases:				
Inpatient	2,309	2,346	9,101	9,176
Outpatient	6,326	6,606	25,118	25,957
Total Surgical Cases	8,635	8,952	34,219	35,133
Physician Office Visits	108,585	95,229	310,077	264,671

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2013 and June 30, 2012.

	FY13 All Year	FY12 All Year
Medicare	30.9%	32.1%
Medicare Managed Care	22.3%	20.8%
Medicaid	11.5%	11.4%
Managed Care	24.8%	25.3%
Self	7.6%	7.7%
Other	2.9%	2.7%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	<u>As of</u>	<u>As of</u>
	<u>6/30/13</u>	<u>6/30/12</u>
Assets		
Current assets:		
Cash and cash equivalents	\$ 55,958	\$ 44,930
Assets limited to use that are required for current liabilities	5,061	4,372
Patient accounts receivable	107,029	108,265
Other receivables	17,995	23,805
Inventories	18,361	17,862
Prepaid expenses & other current assets	8,949	7,462
Total current assets	<u>213,353</u>	<u>206,696</u>
Assets limited as to use, net of current portion	<u>375,709</u>	<u>339,030</u>
Land, buildings and equipment, net	<u>474,730</u>	<u>458,048</u>
Other assets:		
Long-term investments	28,628	36,633
Investments in affiliates	31,874	32,646
Deferred debt expense, net	5,178	5,419
Goodwill, net	15,096	17,090
Other	547	651
	<u>81,323</u>	<u>92,439</u>
Total assets	<u>\$ 1,145,115</u>	<u>\$ 1,096,213</u>
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	\$ 15,002	\$ 11,913
Accounts payable and accrued expenses	84,300	81,243
Estimated third-party payor settlements	7,157	15,535
Current portion of other long-term liabilities	6,198	5,782
Total current liabilities	<u>112,657</u>	<u>114,473</u>
Long-term debt, less current portion	475,946	459,654
Other long-term liabilities, less current portion	41,567	54,060
Total liabilities	<u>630,170</u>	<u>628,187</u>
Net assets:		
Unrestricted	503,934	458,218
Temporarily restricted	6,927	5,739
Permanently restricted	1,311	1,304
Noncontrolling interests	2,773	2,765
Total net assets	<u>514,945</u>	<u>468,026</u>
Commitments and contingencies		
Total liabilities and net assets	<u>\$ 1,145,115</u>	<u>\$ 1,096,213</u>

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	FY13 QTR 4	FY12 QTR 4	FY13 FYTD	FY12 FYTD
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	206,684	209,538	809,517	811,882
Provision for bad debts	(16,158)	(21,464)	(55,029)	(71,407)
Net patient service revenue less provision for bad debts	190,526	188,074	754,488	740,475
Other revenue	9,960	21,352	43,735	47,904
Total revenue	200,486	209,426	798,223	788,379
Expenses:				
Salaries and benefits	96,866	96,505	381,210	368,288
Medical supplies and drugs	43,207	41,004	163,922	164,350
Purchased services	19,836	20,914	80,179	78,731
Interest	5,105	5,428	21,833	21,677
Depreciation and amortization	12,790	12,281	51,319	46,369
Other	20,749	21,741	86,816	86,501
Total expenses	198,553	197,873	785,279	765,916
Income from operations	1,933	11,553	12,944	22,463
Nonoperating gains (losses):				
Investment income	2,881	6,631	19,467	17,272
Derivative valuation adjustments	865	5,304	2,356	1,807
Nonoperating (losses), net	3,746	11,935	21,823	19,079
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	5,679	23,488	34,767	41,542
Discontinued operations	(2,253)	107	(2,167)	(52)
Revenues and gains in excess of expenses and losses	3,426	23,595	32,600	41,490
Income attributable to noncontrolling interests	(233)	(505)	(1,228)	(1,670)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	3,193	23,090	31,372	39,820
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(9,523)	(9,041)	6,157	(9,534)
Net assets released from restrictions for additions to land, buildings, and equipment	34	2,776	828	3,766
Change in the funded status of benefit plans and other	7,359	(10,495)	7,359	(10,495)
Increase (decrease) in unrestricted net assets	1,063	6,330	45,716	23,557
Changes in temporarily restricted net assets:				
Contributions	119	431	2,977	6,661
Net assets released from temporary restrictions	(239)	(2,963)	(1,789)	(4,492)
Increase in temporarily restricted net assets	(120)	(2,532)	1,188	2,169
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	1	128	7	130
Increase (decrease) in permanently restricted net assets	1	128	7	130
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	199	505	1,228	1,670
Distributions to noncontrolling interests	(20)	(369)	(1,220)	(1,261)
Increase (decrease) in noncontrolling interests	179	136	8	409
Change in net assets	1,123	4,062	46,919	26,265
Net assets, beginning of period	513,822	463,964	468,026	441,761
Net assets, end of period	\$514,945	\$468,026	\$514,945	\$468,026

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2013 and June 30, 2012
(Dollars in Thousands)(Unaudited)

	FY13 FYTD	FY12 FYTD
Cash flows from operating activities:		
Change in net assets	\$ 46,919	\$ 26,265
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,319	46,369
Net realized and unrealized (gains) losses on investments	(25,624)	(7,738)
Derivative valuation adjustments	(2,356)	(1,807)
(Gain) loss on sale of fixed assets	209	(458)
Increase (decrease) in cash due to changes in:		
Accounts Receivable	1,235	(6,700)
Inventories	(499)	(32)
Prepaid expenses and other current assets	3,634	(299)
Accounts payable and accrued expenses	3,056	10,300
Net decrease (increase) in other assets	(6,267)	(11,588)
Net cash provided by operating activities	71,626	54,312
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(68,209)	(44,305)
Transfer (to)/from Bond and Self-Insurance funds	8,230	1,122
Transfer (to)/from Board funds	(20,000)	(2,173)
Acquisitions	0	(813)
Net cash (used) in investing activities	(79,979)	(46,169)
Cash flows from financing activities:		
Proceeds from long term debt	33,855	11,368
Repayment of long term debt	(14,474)	(11,139)
Net cash provided (used) in financing activities	19,381	229
Increase (decrease) in cash and cash equivalents	11,028	8,372
Cash and cash equivalents, beginning	44,930	36,558
Cash and cash equivalents, ending	\$ 55,958	\$ 44,930

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

	6/30/13	6/30/12
<u>Capitalization</u>		
Current portion of long-term debt	\$ 15,002	\$ 11,913
Short-term notes payable		
Long-term debt, less current portion	A 475,946	459,654
Total debt	<u>490,948</u>	<u>471,567</u>
Unrestricted net assets	B 503,934	458,218
Other net assets	11,011	9,808
Total net assets	<u>514,945</u>	<u>468,026</u>
Long-term debt plus Unrestricted net assets	A+B <u>\$979,880</u>	<u>\$ 917,872</u>
Long-term debt to Capitalization	A/(A+B) <u>0.486</u>	<u>0.501</u>
<u>Debt Service Coverage</u>		
Revenue and gains in excess of expenses and losses (12 months)	\$ 31,372	\$ 39,820
Add back:		
Depreciation and amortization (12 months)	51,319	46,369
Interest expense (12 months)	21,833	21,677
(Gain) loss from discontinued operations (12 months)	2,167	52
Total income available for debt service per Master Trust Indenture	C <u>106,691</u>	<u>107,918</u>
Maximum annual debt service	D <u>\$ 41,310</u>	<u>\$ 35,157</u>
Debt Service Coverage Ratio per Master Trust Indenture	C/D <u>2.58</u>	<u>3.07</u>
<u>Days Cash on Hand</u>		
Unrestricted cash	\$ 55,958	\$ 44,930
Unrestricted investments:		
Capital improvements	341,596	297,981
Long-term investments	28,628	36,633
Less illiquid investments	(27,528)	(38,621)
	E <u>398,654</u>	<u>340,923</u>
Operating expenses (12 months)	785,279	765,916
Less depreciation and amortization	(51,319)	(46,369)
Total cash expenses	<u>733,960</u>	<u>719,547</u>
Number of days in the period	365	366
Daily cash operating expenses	F <u>\$ 2,011</u>	<u>\$ 1,966</u>
Days cash on hand	E/F <u>198.3</u>	<u>173.4</u>

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
June 30, 2014 and June 30, 2013**

**Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2014 and June 30, 2013**

The following financial statements are unaudited but agree to
the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2014

Note that the closure of Lee Regional Medical Center on October 1, 2013 has been reflected as a discontinued operation for all periods presented.

Volumes:

Quarter ended June 30, 2014 versus quarter ended June 30, 2013:

Volumes were generally down compared to the same quarter last year. Inpatients were down 271 or 3.2% and observation patients were down 368 or 9.7% (so total "patients in a bed" were down 639 or 5.2%) primarily due to reduced utilization from the implementation of the accountable care organizations and high deductible plans in our area. Emergency room visits were up 3.1% and surgeries were down 4.1%, with all of the surgery decrease coming from the ambulatory surgery centers which is attributed to the increase in high deductible plans in our area. Deliveries were down 69 or 12.3% but this appears to be a random fluctuation. Physician office visits were flat overall, despite an increase of 27.3% in urgent care visits due to Wellmont now having four urgent care centers.

Fiscal Year:

Volumes were mixed compared to the prior fiscal year. Inpatients were down 2,066 or 5.7% and observation patients were up 1,192 or 9.2% (so total "patients in a bed" were down 874 or 1.8%) primarily due to reduced utilization from the implementation of the accountable care organizations and high deductible plans in our area. Emergency room visits were down 4.7% due to Wellmont now having four urgent care centers and surgeries were down 2.2%, with all of the surgery decrease coming from the ambulatory surgery centers which is attributed to the increase in high deductible plans in our area. Deliveries were down 99 or 4.3%. Physician office visits were up 2.6%, including urgent care visits which were up 30.5% due to Wellmont now having four urgent care centers.

Statement of Operations:

Quarter ended June 30, 2014 versus quarter ended June 30, 2013:

Net patient service revenue increased \$1.7 million or 0.9% from the same quarter last year (bad debt is down but there is an offsetting increase in charity care in the line above). The acquisition of Wexford House and consolidation of Holston Valley Imaging Center added \$6.4 million of net revenue, while the same store net revenue decreased \$4.7 million due to Medicare reimbursement reductions and volume decreases.

Other revenue decreased \$2.7 million primarily as a result of (a) \$1.8 million of Electronic Health Record Meaningful Use amounts earned during the quarter being \$0.6 million below the prior year amounts of \$2.4 million due to the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of \$0.9 million due to the loss of a significant contract, and (c) \$0.4 million from lower performance of the managed care, home care and Takoma joint ventures.

Salaries and benefits increased slightly by \$0.4 million or 0.4%. Supplies decreased \$3.0 million or 7.0% primarily due to the lower volumes and increased savings from chemotherapy drugs. Purchased services increased slightly by \$0.3 million or 1.6%. Interest expense decreased slightly by \$0.3 million or 5.9% due to the capitalization of interest for the Epic electronic health record project and scheduled decreases in outstanding principal. Depreciation increased by \$2.0 million or 16.1% due to the Epic system going live at the beginning of April. Lease and rental decreased by \$0.7 million or 15.7% due to the conversion of some operating leases to capital leases. Other expenses increased by \$4.4 million or 84% primarily due to an increase in the professional and general liability actuarial expense of \$3.3 million and to the change in allocation of support services costs as a result of the closure of Lee Regional Medical Center.

The loss from operations of (\$1.3 million) was worse than the same quarter last year by \$3.8 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$3.6 million was above the same quarter last year by \$0.5 million due primarily to a \$4.7 million increase in investment income and a \$1.8 million decrease in the loss from discontinued operations, offset by a \$0.7 million decrease in derivative valuation adjustments, a \$1.1 million loss on refinancing, and the \$3.8 million decrease in income from operations.

Fiscal Year:

Net patient service revenue increased \$5.3 million or 0.7% compared to the prior fiscal year (bad debt is down but there is an offsetting increase in charity care in the line above). The acquisition of Wexford House and consolidation of Holston Valley Imaging Center added \$11.3 million of net revenue, while the same store net revenue decreased \$6.0 million due to Medicare reimbursement reductions and volume decreases.

Other revenue decreased \$12.7 million primarily as a result of (a) \$7.2 million of Electronic Health Record Meaningful Use amounts earned being \$5.1 million below the prior year amounts of \$12.3 million due to the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of \$3.4 million due to the loss of a significant contract, and (c) \$1.9 million from lower performance of the managed care, home care and Takoma joint ventures.

Salaries and benefits increased slightly by \$1.2 million or 0.3%. Supplies increased \$4.1 million or 2.5% primarily in chemotherapy drug volume and cost. Purchased services decreased \$4.0 million or 5.2% due to changes in physician agreements. Interest expense decreased by \$1.9 million or 9.6% due to the capitalization of interest for the Epic electronic health record project and scheduled decreases in outstanding principal. Depreciation increased by \$0.6 million or 1.2%. Lease and rental decreased by \$2.4 million or 13.3% due to the conversion of some operating leases to capital leases. Other expenses increased \$5.6 million or 20.8% primarily

due to an increase in the professional and general liability expense of \$3.5 million and to the change in allocation of support services costs as a result of the closure of Lee Regional Medical Center.

Income from operations of \$4.8 million was below the prior fiscal year to date by \$10.6 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$6.3 million was below the prior fiscal year by \$25.0 million due to the impairment of Lee Regional Medical Center of \$22.5 million included in the \$26.6 million loss on discontinued operations, the \$10.6 million decrease in income from operations, a \$4.6 million decrease in investment income, a \$1.1 million loss on refinancing, and a \$1.0 million decrease in derivative valuation adjustments, offset by the \$14.7 million gain on conversion from the equity method to consolidation of Holston Valley Imaging Center on March 31, 2014.

Balance Sheet and Ratios:

The significant changes in the balance sheet were (a) expenditures for the Epic electronic health record project of \$60.2 million and draws on the financing thereof of \$26.7 million, (b) the acquisition of Wexford House of \$13.5 million (\$5.8 million land, buildings and equipment and \$7.7 million goodwill), (c) the acquisition of the remaining 25% of Holston Valley Imaging Center of \$7.9 million (all goodwill), (d) the associated conversion of Holston Valley Imaging Center from the equity method to consolidation which resulted in an increase in goodwill of \$21.5 million, (e) the impairment of Lee Regional Medical Center of \$22.5 million (\$21.7 million buildings and equipment and \$0.8 million goodwill) and (f) the sale of Wellmont Health System's 60% interest in Takoma Regional Hospital of \$11.7 million as of July 1, 2014 (the cash was received on June 30, 2014 and is in other current liabilities). In addition, the 2003, 2005 and 2010 series of debt were refinanced in June with new direct placement tax-exempt debt.

Days cash on hand increased as a result of the above activity and appreciation of the investment portfolio. The debt to capitalization ratio improved slightly. The debt service coverage ratio decreased due to income available for debt service being \$17.8 million lower and MADS being \$1.5 million higher.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal ye ended June 30, 2014 and June 30, 2013 (restated to remove Lee Regional as it is now a discontinued operation).

	FY14 QTR 4	FY13 QTR 4	FY14 All Year	FY13 All Year
Hospital Statistics:				
Acute Discharges	8,300	8,571	34,365	36,431
Observation Patients	3,430	3,798	14,205	13,013
Patients in Bed	11,730	12,369	48,570	49,444
Patient Days	35,882	35,606	145,845	157,541
Average Length of Stay (Days)	4.32	4.15	4.24	4.32
Daily Census including Observations	432	433	438	467
Emergency Room Visits	43,463	42,140	170,331	178,691
Deliveries	491	560	2,210	2,309
Surgical Cases:				
Inpatient	2,391	2,341	9,430	9,279
Outpatient	6,103	6,517	24,896	25,804
Total Surgical Cases	8,494	8,858	34,326	35,083
Physician Office Visits	108,976	108,847	429,656	418,924
including Urgent Care Visits	12,424	9,763	44,344	33,993

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2014 and June 30, 2013.

	FY14 All Year	FY13 All Year
Medicare	30.7%	31.0%
Medicare Managed Care	23.6%	23.5%
Medicaid	11.1%	10.9%
Managed Care/Other	27.7%	27.9%
Self	6.9%	6.7%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	<u>As of</u> <u>6/30/14</u>	<u>As of</u> <u>6/30/13</u>
Assets		
Current assets:		
Cash and cash equivalents	\$ 30,674	\$ 55,958
Assets limited to use that are required for current liabilities	3,233	5,061
Patient accounts receivable	117,265	107,029
Other receivables	14,685	17,995
Inventories	18,684	18,361
Prepaid expenses & other current assets	10,337	8,949
Total current assets	194,878	213,353
Assets limited as to use, net of current portion	425,740	375,709
Land, buildings and equipment, net	492,581	474,730
Other assets:		
Long-term investments	32,521	28,628
Investments in affiliates	18,221	31,874
Deferred debt expense, net	4,226	5,178
Goodwill, net	51,649	15,096
Other	520	547
	107,137	81,323
Total assets	\$ 1,220,336	\$ 1,145,115
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	\$ 18,015	\$ 15,002
Accounts payable and accrued expenses	90,547	84,300
Estimated third-party payor settlements	8,425	7,157
Current portion of other long-term liabilities	6,510	6,198
Other current liabilities	11,700	0
Total current liabilities	135,197	112,657
Long-term debt, less current portion	490,443	475,946
Other long-term liabilities, less current portion	43,866	41,567
Total liabilities	669,506	630,170
Net assets:		
Unrestricted	538,607	503,934
Temporarily restricted	8,214	6,927
Permanently restricted	1,319	1,311
Noncontrolling interests	2,690	2,773
Total net assets	550,830	514,945
Commitments and contingencies		
Total liabilities and net assets	\$ 1,220,336	\$ 1,145,115

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	FY14 QTR 4	FY13 QTR 4	FY14 All Year	FY13 All Year
Revenue:				
Patient service revenue (net of contractual allowances and discounts)	\$193,547	\$201,740	788,910	791,230
Provision for bad debts	(5,396)	(15,323)	(45,644)	(53,251)
Net patient service revenue less provision for bad debts	188,151	186,417	743,266	737,979
Other revenue	6,841	9,507	29,441	42,127
Total revenue	194,992	195,924	772,707	780,106
Expenses:				
Salaries and benefits	95,323	94,963	374,309	373,150
Medical supplies and drugs	39,850	42,850	166,676	162,604
Purchased services	19,537	19,231	73,674	77,716
Interest	4,441	4,720	18,350	20,292
Depreciation and amortization	14,310	12,330	50,058	49,465
Maintenance and utilities	9,303	9,497	36,978	36,830
Lease and rental	3,840	4,554	15,506	17,892
Other	9,722	5,284	32,312	26,745
Total expenses	196,326	193,429	767,863	764,694
Income (loss) from operations	(1,334)	2,495	4,844	15,412
Nonoperating gains (losses):				
Investment income	7,531	2,879	14,749	19,316
Derivative valuation adjustments	189	865	1,307	2,356
Loss on refinancing	(1,133)	-	(1,133)	-
Gain on revaluation of equity method investment	-	-	14,744	-
Nonoperating gains (losses), net	6,587	3,744	29,667	21,672
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	5,253	6,239	34,511	37,084
Discontinued operations	(1,128)	(2,943)	(26,639)	(4,484)
Revenues and gains in excess of expenses and losses	4,125	3,296	7,872	32,600
Income attributable to noncontrolling interests	(571)	(234)	(1,540)	(1,228)
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	3,554	3,062	6,332	31,372
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	7,968	(9,426)	28,333	6,157
Net assets released from restrictions for additions to land, buildings, and equipment	(192)	34	901	828
Change in funded status of benefit plans and other	(893)	7,359	(893)	7,359
Increase (decrease) in unrestricted net assets	10,437	1,029	34,673	45,716
Changes in temporarily restricted net assets:				
Contributions	454	217	2,707	2,977
Net assets released from temporary restrictions	99	(337)	(1,420)	(1,789)
Increase (decrease) in temporarily restricted net assets	553	(120)	1,287	1,188
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	5	1	8	7
Increase in permanently restricted net assets	5	1	8	7
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	571	234	1,540	1,228
Distributions to noncontrolling interests	(307)	(21)	(1,623)	(1,220)
Increase (decrease) in noncontrolling interests	264	213	(83)	8
Change in net assets	11,259	1,123	35,885	46,919
Net assets, beginning of period	539,571	513,822	514,945	468,026
Net assets, end of period	\$550,830	\$514,945	\$550,830	\$514,945

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2014 and June 30, 2013
(Dollars in Thousands)(Unaudited)

	FY14		FY13
	All Year		All Year
Cash flows from operating activities:			
Change in net assets	\$ 35,885	\$	46,919
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:			
Depreciation and amortization	50,058		49,465
Net realized and unrealized (gains) losses on investments	(43,082)		(25,473)
Derivative valuation adjustments	(1,307)		(2,356)
(Gain) loss on sale of fixed assets	(78)		209
Loss on refinancing	1,133		0
(Gain) on revaluation of equity method investment	(14,744)		0
Impairment of assets	22,456		0
Increase (decrease) in cash due to changes in:			
Accounts Receivable	(10,236)		1,235
Inventories	(323)		(499)
Prepaid expenses and other current assets	3,750		3,634
Accounts payable and accrued expenses	7,498		3,056
Net decrease (increase) in other assets	3,723		(4,564)
Net cash provided by operating activities	<u>54,733</u>		<u>71,626</u>
Cash flows from investing activities:			
Purchases of property, plant and equipment, net	(69,074)		(68,209)
Transfer (to)/from Bond and Self-Insurance funds	(5,837)		8,230
Transfer (to)/from Board funds	0		(20,000)
Acquisitions	(22,637)		0
Net cash (used) in investing activities	<u>(97,548)</u>		<u>(79,979)</u>
Cash flows from financing activities:			
Proceeds from long term debt	128,623		33,855
Repayment of long term debt	(111,092)		(14,474)
Net cash provided (used) in financing activities	<u>17,531</u>		<u>19,381</u>
Increase (decrease) in cash and cash equivalents	(25,284)		11,028
Cash and cash equivalents, beginning	<u>55,958</u>		<u>44,930</u>
Cash and cash equivalents, ending	<u>\$ 30,674</u>	\$	<u>55,958</u>

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

	6/30/14	6/30/13
<u>Capitalization</u>		
Current portion of long-term debt	\$ 18,015	\$ 15,002
Short-term notes payable		
Long-term debt, less current portion	A 490,443	475,946
Total debt	<u>508,458</u>	<u>490,948</u>
Unrestricted net assets	B 538,607	503,934
Other net assets	12,223	11,011
Total net assets	<u>550,830</u>	<u>514,945</u>
Long-term debt plus Unrestricted net assets	A+B \$ 1,029,050	\$ 979,880
Long-term debt to Capitalization	A/(A+B) 0.477	0.486
<u>Debt Service Coverage</u>		
Revenue and gains in excess of expenses and losses (12 months)	\$ 6,332	\$ 31,372
Add back:		
Depreciation and amortization	50,058	49,465
Interest expense	18,350	20,292
Loss on refinancing	1,133	-
(Gain) on revaluation of equity method investment	(14,744)	-
Loss from discontinued operations	26,639	4,484
Total income available for debt service per Master Trust Indenture	C <u>87,768</u>	<u>105,613</u>
Maximum annual debt service	D \$ 42,797	\$ 41,310
Debt Service Coverage Ratio per Master Trust Indenture	C/D 2.05	2.56
<u>Days Cash on Hand</u>		
Unrestricted cash	\$ 30,674	\$ 55,958
Unrestricted investments:		
Capital improvements	383,962	341,596
Long-term investments	32,521	28,628
Less illiquid investments	(28,364)	(27,528)
	E <u>418,793</u>	<u>398,654</u>
Operating expenses (12 months)	767,863	764,694
Less depreciation and amortization	(50,058)	(49,465)
Total cash expenses	<u>717,805</u>	<u>715,229</u>
Number of days in the period	365	365
Daily cash operating expenses	F \$ 1,967	\$ 1,960
Days cash on hand	E/F <u>213.0</u>	<u>203.4</u>

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates

**Consolidated Balance Sheets as of
June 30, 2015 and June 30, 2014**

**Consolidated Statements of Operations and Changes in Net Assets
and Statements of Cash Flows for the Quarters and Fiscal Years ended
June 30, 2015 and June 30, 2014**

The following financial statements are unaudited but
agree to the annual independent audit.

Wellmont Health System
Management Discussion and Analysis
For the Quarter and Fiscal Year ended June 30, 2015

Note that the closure of Lee Regional Medical Center on October 1, 2013 has been reflected as a discontinued operation for all periods presented.

Overview:

Wellmont Health System had income from operations of \$6.7 million and net income of \$15.4 million for the fiscal year ended June 30, 2015. Net patient service revenue increased 6.4%. Adjusting to the trend of more care delivered in outpatient facilities, Wellmont has opened additional urgent care centers, which have provided a way for patients to receive assistance for pressing health needs that can be addressed without an expensive trip to the emergency department. This also reflects the health system's goal to increase health care access points in the area and reshape the way the region receives care in lower cost outpatient settings. That has resulted in a 56% increase in urgent care patient volumes during fiscal 2015, when a new center opened in Lebanon, Virginia, and the Bristol and Kingsport, Tennessee centers operated for their first full years. The health system also operates urgent care centers in Johnson City, Tennessee; Abingdon, Virginia; and Norton, Virginia. The opening of another facility for cancer patients, this one in Bristol, Virginia, further extended Wellmont's community outreach. Open since January, this facility features services such as oncology, hematology, genetic counseling, high-risk cancer clinic, clinical trials, nutrition services and social work. This is the fifth office for the Wellmont Cancer Institute. During fiscal 2015, the number of infusion patient visits across the system increased by 64%. The following volume and financial details provide additional information on Wellmont's growing strength in service to the community.

Volumes:

Total patients in a bed were up 1.2% for the year as we continue the transition to value based payments while facing the challenge of increasingly prevalent high deductible health plans in our area. While emergency room visits were up 4.7%, surgeries were down 2.3% and deliveries were up 1.6%. Outpatient volumes were up, especially due to the expansion of infusion centers (visits up 64%) and urgent care centers (visits up 56% for year) as we continue to expand the portals of entry into our health system.

Statement of Operations:

Quarter ended June 30, 2015 versus quarter ended June 30, 2014:

Net patient service revenue increased \$17.3 million or 9.2% from the same quarter last year due primarily to a 13.2% increase in outpatient revenue. Other revenue decreased \$1.5 million primarily as a result of (a) \$0.6 million of Electronic Health Record Meaningful Use amounts earned during the quarter being \$1.2 million below the prior year amounts of \$1.8 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments and (b) blood bank revenue reductions of \$0.3 million due to the loss of a significant contract.

Salaries and benefits increased \$12.8 million or 13.5% as a result of (a) one-time five year physician retention compensation earned and (b) an increase in employee health costs for the last quarter due to higher utilization. Supplies increased 5.3% primarily due to higher infusion volumes. Purchased services decreased 2.3%. Interest expense decreased 0.3%. Depreciation increased 7.8% due to the Epic system going live in April 2014. All other expenses decreased 10.9% due primarily to a significantly lower professional and general liability expense from the preliminary actuarial report.

Income from operations of \$1.4 million was above the same quarter last year by \$2.7 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$1.6 million was below the same quarter last year by \$2.0 million.

Fiscal Year:

Net patient service revenue increased \$47.7 million or 6.4% compared to the prior fiscal year due to (a) the Wexford House acquisition in December 2013 and the HVIC acquisition at the end of March 2014 and (b) the increase in outpatient revenue. Other revenue decreased \$7.7 million primarily as a result of (a) \$3.2 million of Electronic Health Record Meaningful Use amounts earned being \$4.0 million below the prior year amounts of \$7.2 million due to reduced payments from lower volumes and the scheduled annual decreases in the program's payments, (b) blood bank revenue reductions of \$1.7 million due to the loss of a significant contract, and (c) \$3.0 million decrease from the prior investment in HVIC now being consolidated in each line of the statement of operations.

Salaries and benefits increased \$25.6 million or 6.9% as a result of (a) the acquisitions noted above and (b) one-time five year physician retention compensation earned. Supplies were up 1.2%. Purchased services increased 2.8%. Interest expense decreased 3.2%. Depreciation increased \$8.5 million or 17.0% due to the Epic system going live in April 2014. All other expenses increased 0.6%.

Income from operations of \$6.7 million was above the prior fiscal year by \$1.9 million. Net income (shown as "Revenues and gains in excess of expenses and losses attributable to Wellmont Health System") of \$15.4 million was above the prior fiscal year by \$9.0 million. The prior fiscal year was impacted by (a) the impairment of Lee Regional Medical Center of \$22.5 million included in the \$26.6 million of discontinued operations, offset somewhat by (b) the \$14.7 million gain on conversion from equity to consolidation for the HVIC acquisition.

Balance Sheet and Ratios:

The only significant changes in the balance sheet were the sale of Wellmont Health System's 60% interest in Takoma Regional Hospital of \$11.7 million as of July 1, 2014 (the cash was received on June 30, 2014 and was in other current liabilities). In addition, a portion of the Series 2006C debt was advance refunded in September 2014 with new direct placement tax-exempt debt. Cash on hand decreased by 2 days and the debt to capitalization ratio and debt service coverage ratio both improved slightly.

Wellmont Health System and Affiliates

The following table sets forth selected historical utilization statistics for the quarters and fiscal years ended June 30, 2015 and June 30, 2014.

	FY15 QTR 4	FY14 QTR 4	FY15 All Year	FY14 All Year
Hospital Statistics:				
Acute Discharges	7,980	8,300	33,045	34,356
Observation Patients	4,570	3,430	16,693	14,779
Patients in Bed	12,550	11,730	49,738	49,135
Patient Days	33,661	35,882	144,579	145,845
Average Length of Stay (Days)	4.22	4.32	4.38	4.25
Daily Census including Observations	420	432	442	440
Emergency Room Visits	45,433	43,463	178,324	170,331
Deliveries	448	491	2,246	2,210
Surgical Cases:				
Inpatient	2,239	2,391	9,125	9,430
Outpatient	5,932	6,103	24,396	24,896
Total Surgical Cases	8,171	8,494	33,521	34,326
Physician Office Visits				
including Urgent Care Visits	123,390	108,976	474,762	429,656
	16,902	12,424	69,421	44,344

The following table shows the percentage of gross patient service revenue by payor for the fiscal years ended June 30, 2015 and June 30, 2014.

	FY15 All Year	FY14 All Year
Medicare	30.6%	30.7%
Medicare Managed Care	23.4%	23.6%
Medicaid	11.3%	11.1%
Managed Care/Other	27.9%	27.7%
Self	6.8%	6.9%
	100.0%	100.0%

Wellmont Health System and Affiliates
Consolidated Balance Sheets
As of June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	As of 6/30/15	As of 6/30/14
Assets		
Current assets:		
Cash and cash equivalents	\$ 48,866	\$ 30,674
Assets limited to use that are required for current liabilities	3,651	4,066
Patient accounts receivable	112,299	117,265
Other receivables	11,238	14,685
Inventories	19,981	18,684
Prepaid expenses & other current assets	9,979	10,337
Total current assets	206,014	195,711
Assets limited as to use, net of current portion	424,864	424,907
Land, buildings and equipment, net	484,569	492,581
Other assets:		
Long-term investments	27,964	32,521
Investments in affiliates	7,214	18,221
Deferred debt expense, net	4,217	4,226
Goodwill, net	51,583	51,649
Other	525	520
	91,503	107,137
Total assets	\$ 1,206,950	\$ 1,220,336
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	\$ 18,626	\$ 18,015
Accounts payable and accrued expenses	101,871	90,547
Estimated third-party payor settlements	12,987	8,425
Current portion of other long-term liabilities	7,660	6,510
Other current liabilities	0	11,700
Total current liabilities	141,144	135,197
Long-term debt, less current portion	480,187	490,443
Other long-term liabilities, less current portion	39,097	43,866
Total liabilities	660,428	669,506
Net assets:		
Unrestricted	535,632	538,607
Temporarily restricted	6,960	8,214
Permanently restricted	1,323	1,319
Noncontrolling interests	2,607	2,690
Total net assets	546,522	550,830
Commitments and contingencies		
Total liabilities and net assets	\$ 1,206,950	\$ 1,220,336

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statements of Operations and Changes in Net Assets
The quarters and fiscal years ended June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	FY15 QTR 4	FY14 QTR 4	FY15 All Year	FY14 All Year
Revenue:				
Net patient service revenue less provision for bad debts	\$ 205,481	\$ 188,151	\$ 790,970	\$ 743,266
Other revenue	5,300	6,841	21,759	29,441
Total revenue	<u>210,781</u>	<u>194,992</u>	<u>812,729</u>	<u>772,707</u>
Expenses:				
Salaries and benefits	108,150	95,323	399,955	374,309
Medical supplies and drugs	41,977	39,850	168,678	166,676
Purchased services	19,086	19,537	75,749	73,674
Interest	4,428	4,441	17,757	18,350
Depreciation and amortization	15,428	14,310	58,569	50,058
Maintenance and utilities	10,039	9,303	39,764	36,978
Lease and rental	4,046	3,840	15,435	15,506
Other	6,272	9,722	30,128	32,312
Total expenses	<u>209,426</u>	<u>196,326</u>	<u>806,035</u>	<u>767,863</u>
Income from operations	<u>1,355</u>	<u>(1,334)</u>	<u>6,694</u>	<u>4,844</u>
Nonoperating gains (losses):				
Investment income	2,528	7,531	14,207	14,749
Derivative valuation adjustments	(1,697)	189	(563)	1,307
Gain on revaluation of equity method investment	-	-	-	14,744
Loss on refinancing	-	(1,133)	(1,389)	(1,133)
Nonoperating gains (losses), net	<u>831</u>	<u>6,587</u>	<u>12,255</u>	<u>29,667</u>
Revenues and gains in excess of expenses and losses before discontinued operations and noncontrolling interests	2,186	5,253	18,949	34,511
Discontinued operations	(532)	(1,128)	(2,720)	(26,639)
Revenues and gains in excess of expenses and losses	<u>1,654</u>	<u>4,125</u>	<u>16,229</u>	<u>7,872</u>
Income attributable to noncontrolling interests	<u>(73)</u>	<u>(571)</u>	<u>(866)</u>	<u>(1,540)</u>
Revenues and gains in excess of expenses and losses attributable to Wellmont Health System	1,581	3,554	15,363	6,332
Other changes in unrestricted net assets:				
Change in net unrealized gains (losses) on investments	(4,160)	7,968	(18,555)	28,333
Net assets released from restrictions for additions to land, buildings, and equipment	384	(192)	2,712	901
Change in funded status of benefit plans and other	(2,495)	(893)	(2,495)	(893)
Increase (decrease) in unrestricted net assets	<u>(4,690)</u>	<u>10,437</u>	<u>(2,975)</u>	<u>34,673</u>
Changes in temporarily restricted net assets:				
Contributions	170	454	2,545	2,707
Net assets released from temporary restrictions	(668)	99	(3,799)	(1,420)
Increase (decrease) in temporarily restricted net assets	<u>(498)</u>	<u>553</u>	<u>(1,254)</u>	<u>1,287</u>
Changes in permanently restricted net assets:				
Permanently restricted contributions and investment income	1	5	4	8
Increase (decrease) in permanently restricted net assets	<u>1</u>	<u>5</u>	<u>4</u>	<u>8</u>
Changes in noncontrolling interests:				
Income attributable to noncontrolling interests	73	571	866	1,540
Distributions to noncontrolling interests	(337)	(307)	(949)	(1,623)
Increase (decrease) in noncontrolling interests	<u>(264)</u>	<u>264</u>	<u>(83)</u>	<u>(83)</u>
Change in net assets	<u>(5,451)</u>	<u>11,259</u>	<u>(4,308)</u>	<u>35,885</u>
Net assets, beginning of period	551,973	539,571	550,830	514,945
Net assets, end of period	<u>\$ 546,522</u>	<u>\$ 550,830</u>	<u>\$ 546,522</u>	<u>\$ 550,830</u>

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Consolidated Statement of Cash Flows
The fiscal years ended June 30, 2015 and June 30, 2014
(Dollars in Thousands)(Unaudited)

	FY15	FY14
	All Year	All Year
Cash flows from operating activities:		
Change in net assets	\$ (4,308)	\$ 35,885
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities:		
Depreciation and amortization	58,569	50,058
Net realized and unrealized (gains) losses on investments	4,348	(43,082)
Derivative valuation adjustments	563	(1,307)
(Gain) loss on sale of fixed assets	(569)	(78)
(Gain) on conversion from equity to consolidation	0	(14,744)
Loss on refinancing	1,389	1,133
Impairment of assets	0	22,456
Increase (decrease) in cash due to changes in:		
Accounts Receivable	4,966	(10,236)
Inventories	(1,297)	(323)
Prepaid expenses and other current assets	3,731	3,750
Accounts payable and accrued expenses	(375)	7,498
Net decrease (increase) in other assets	11,476	3,723
Net cash provided by operating activities	78,493	54,733
Cash flows from investing activities:		
Purchases of property, plant and equipment, net	(50,054)	(69,074)
Transfer (to)/from Bond and Self-Insurance funds	(602)	(5,837)
Transfer (to)/from Board funds	0	0
Acquisitions	0	(22,637)
Net cash (used) in investing activities	(50,656)	(97,548)
Cash flows from financing activities:		
Proceeds from long term debt	26,064	128,623
Repayment of long term debt	(35,709)	(111,092)
Net cash provided (used) in financing activities	(9,645)	17,531
Increase (decrease) in cash and cash equivalents	18,192	(25,284)
Cash and cash equivalents, beginning	30,674	55,958
Cash and cash equivalents, ending	\$ 48,866	\$ 30,674

Certain amounts have been reclassified to conform to the current presentation.

Wellmont Health System and Affiliates
Ratios
(Dollars in thousands)

	6/30/15	6/30/14
<u>Capitalization</u>		
Current portion of long-term debt	\$ 18,626	\$ 18,015
Short-term notes payable		
Long-term debt, less current portion	A 480,187	490,443
Total debt	<u>498,813</u>	<u>508,458</u>
Unrestricted net assets	B 535,632	538,607
Other net assets	10,890	12,223
Total net assets	<u>546,522</u>	<u>550,830</u>
Long-term debt plus Unrestricted net assets	A+B \$ 1,015,819	\$ 1,029,050
Long-term debt to Capitalization	A/(A+B) 0.473	0.477
<u>Debt Service Coverage</u>		
Revenue and gains in excess of expenses and losses (12 months)	\$ 15,363	\$ 6,332
Add back:		
Depreciation and amortization (12 months)	58,569	50,058
Interest expense (12 months)	17,757	18,350
(Gain) loss on refinancing	1,389	1,133
(Gain) on revaluation of equity method investment	-	(14,744)
(Gain) loss from discontinued operations (12 months)	2,720	26,639
Total income available for debt service per Master Trust Indenture	C <u>95,798</u>	<u>87,768</u>
Maximum annual debt service	D \$ 43,009	\$ 42,797
Debt Service Coverage Ratio per Master Trust Indenture	C/D 2.23	2.05
<u>Days Cash on Hand</u>		
Unrestricted cash	\$ 48,866	\$ 30,674
Unrestricted investments:		
Capital improvements	382,902	383,962
Long-term investments	27,964	32,521
Less illiquid investments	(28,051)	(28,364)
	E <u>431,681</u>	<u>418,793</u>
Operating expenses (12 months)	806,035	767,863
Less depreciation and amortization	(58,569)	(50,058)
Total cash expenses	<u>747,466</u>	<u>717,805</u>
Number of days in the period	365	365
Daily cash operating expenses	F \$ 2,048	\$ 1,967
Days cash on hand	E/F <u>210.8</u>	<u>213.0</u>

Exhibit 35

Updated Financial Model

Income Statement - NewCo Baseline								
\$'000s	Actuals			Forecasted				
	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	\$ 1,670,727	\$ 1,671,050	\$ 1,813,472	\$ 1,812,747	\$ 1,886,737	\$ 1,924,471	\$ 1,962,961	\$ 2,002,220
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total revenue, gains, & support	1,791,312	1,773,631	1,904,228	1,903,502	1,977,492	2,015,227	2,053,716	2,092,976
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	948,313	960,157	972,150	984,292
Medical supplies & drugs	325,559	330,375	344,718	346,269	362,169	371,224	380,504	390,017
Purchased services	183,607	189,280	196,037	201,918	207,975	214,215	220,641	227,260
Interest & taxes	63,495	62,742	61,453	59,338	57,756	56,216	54,717	53,258
Depreciation & amortization	130,666	121,237	127,336	126,507	126,364	126,828	127,872	129,471
Maintenance & utilities	53,687	54,030	56,561	58,258	60,006	61,806	63,660	65,570
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,622	17,037	17,463
Other	107,995	122,584	143,924	149,681	155,668	161,895	168,371	175,105
Total expenses & losses	1,764,431	1,761,743	1,870,524	1,894,407	1,934,468	1,968,962	2,004,952	2,042,436
Income from operations	26,881	11,888	33,704	9,095	43,024	46,265	48,765	50,540
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	69,770	78,967	22,587	23,099	23,561	24,032	24,512	25,003
Revenues & gains in excess of expenses & losses	96,651	90,855	56,291	32,194	66,585	70,296	73,277	75,542
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Total other non-operating operations	(12,212)	(36,465)	(17,765)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Revenues & gains in excess of expenses & losses attributable to \$	\$ 84,439	\$ 54,390	\$ 38,526	\$ 17,711	\$ 51,586	\$ 55,242	\$ 58,178	\$ 60,409

Balance Sheet - NewCo Baseline									
\$'000s	Actuals			Forecasted					
	6/30/13	6/30/14	6/30/15	Year 1	Year 2	Year 3	Year 4	Year 5	
Current assets:									
Cash & cash equivalents	\$ 130,860	\$ 89,859	\$ 128,580	\$ 99,994	\$ 90,690	\$ 85,045	\$ 76,870	\$ 65,621	
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904	
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704	
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078	
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	64,496	66,108	67,761	69,455	
Total current assets	537,370	516,750	531,680	501,384	508,243	512,190	513,875	512,762	
Other non-current assets:									
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133	
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,335,035	1,346,020	1,362,851	1,385,318	
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179	
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418	
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099	
Total other non-current assets	2,646,822	2,786,166	2,777,303	2,799,052	2,827,778	2,863,191	2,905,049	2,953,148	
Total assets	3,184,192	3,302,916	3,308,983	3,300,436	3,336,021	3,375,381	3,418,924	3,465,910	
Current liabilities:									
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731	
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056	
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394	
Total current liabilities	351,523	354,233	373,985	372,254	379,148	385,017	391,027	397,181	
Non-current liabilities:									
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438	
Retention bonus liability	-	-	-	-	-	-	-	-	
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129	
Total non-current liabilities	1,644,740	1,664,912	1,605,731	1,566,721	1,528,827	1,492,022	1,456,277	1,421,567	
Total liabilities	1,996,263	2,019,145	1,979,715	1,938,975	1,907,975	1,877,038	1,847,304	1,818,748	
Net assets:									
Unrestricted	994,348	1,080,586	1,112,232	1,129,943	1,181,529	1,236,771	1,294,949	1,355,358	
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508	
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450	
Noncontrolling interests	172,439	181,321	195,078	209,560	224,559	239,614	254,713	269,846	
Total net assets	1,187,929	1,283,771	1,329,268	1,361,462	1,428,046	1,498,343	1,571,620	1,647,162	
Total liabilities and net assets	\$ 3,184,192	\$ 3,302,916	\$ 3,308,983	\$ 3,300,436	\$ 3,336,021	\$ 3,375,381	\$ 3,418,924	\$ 3,465,910	

Statement of Cash Flows - NewCo Baseline		Forecasted				
\$'000s	Scenario	Year 1	Year 2	Year 3	Year 4	Year 5
Cash flows from operating activities:						
Income from operations		\$ 9,095	\$ 43,024	\$ 46,265	\$ 48,765	\$ 50,540
Adjustments to reconcile change in net assets to net cash provided by operating activities:						
Depreciation and amortization		126,507	126,364	126,828	127,872	129,471
Loss on extinguishment of debt		-	-	-	-	-
Change in estimated fair value of derivatives		-	-	-	-	-
Equity in net income of JVs, net		-	-	-	-	-
Loss/(Gain) on disposal of assets		-	-	-	-	-
Capital Appreciation Bond accretion and other		-	-	-	-	-
Restricted contributions		-	-	-	-	-
Pension and other defined benefit plan adjustments		-	-	-	-	-
Increase/(Decrease) in cash due to change in:						
Patient accounts receivable, net		1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net		(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses		2,266	(2,832)	(1,612)	(1,653)	(1,694)
Net deferred financing, acquisition costs & other charges		1,449	1,376	1,307	1,242	1,180
Other assets		(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities		-	-	-	-	-
Accounts payable & accrued expenses		(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements		369	377	384	392	400
Other long-term liabilities		1,633	1,665	1,699	1,733	1,767
Total adjustments		127,962	118,480	124,407	125,241	126,627
Net cash provided by operating activities		137,057	161,504	170,672	174,005	177,166
Cash flows from investing activities:						
Purchases of property, plant, and equipment		(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Acquisitions, net of cash acquired		-	-	-	-	-
Non-operating gains, net		23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities		(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates		-	-	-	-	-
Proceeds from sale of plant, property, and equipment		-	-	-	-	-
Net cash used in investing activities		(125,000)	(131,250)	(137,813)	(144,703)	(151,938)
Cash flows from financing activities:						
Payments on LT debt and liabilities, including escrow deposits		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs		-	-	-	-	-
Proceeds from issuance of LT debt & other financings		-	-	-	-	-
Net amounts received on interest rate swaps		-	-	-	-	-
Restricted contributions received		-	-	-	-	-
Net cash used by financing activities		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Net increase/(decrease) in cash and cash equivalents		(28,585)	(9,305)	(5,644)	(8,175)	(11,250)
Cash and cash equivalents at beginning of year		128,580	99,994	90,690	85,045	76,870
Cash and cash equivalents at end of year		\$ 99,994	\$ 90,690	\$ 85,045	\$ 76,870	\$ 65,621

Income Statement - NewCo with Preliminary Efficiency Estimates								
\$'000s	Actuals			Forecasted				
	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	\$ 1,670,727	\$ 1,671,050	\$ 1,813,472	\$ 1,812,747	\$ 1,886,737	\$ 1,924,471	\$ 1,962,961	\$ 2,002,220
Other revenues:								
Other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total other revenues	120,585	102,581	90,756	90,756	90,756	90,756	90,756	90,756
Total revenue, gains, & support	1,791,312	1,773,631	1,904,228	1,903,502	1,977,492	2,015,227	2,053,716	2,092,976
Expenses:								
Salaries, wages, & benefits	881,530	865,989	925,061	936,615	938,313	941,691	935,264	946,416
Medical supplies & drugs	325,559	330,375	344,718	346,269	337,871	340,229	341,842	344,601
Purchased services	183,607	189,280	196,037	201,918	201,785	205,929	209,434	214,233
Interest & taxes	63,495	62,742	61,453	59,338	57,756	55,972	53,882	52,353
Depreciation & amortization	130,666	121,237	127,336	126,507	130,650	142,843	157,111	165,204
Maintenance & utilities	53,687	54,030	56,561	58,258	58,898	60,236	61,363	62,917
Lease & rental	17,892	15,506	15,435	15,821	16,216	16,558	16,820	17,228
Other	107,995	122,584	143,924	149,681	141,334	143,766	146,245	148,940
Total expenses & losses	1,764,431	1,761,743	1,870,524	1,894,407	1,882,824	1,907,224	1,921,961	1,951,892
Income from operations	26,881	11,888	33,704	9,095	94,669	108,003	131,755	141,083
Non-operating gains:								
Investment income	60,296	65,452	4,883	23,099	23,561	24,032	24,512	25,003
Derivative valuation adjustments	9,474	4,526	19,093	-	-	-	-	-
Loss on refinancing	-	(5,755)	(1,389)	-	-	-	-	-
Gain on revaluation of equity method investment	-	14,744	-	-	-	-	-	-
Non-operating gains, net	69,770	78,967	22,587	23,099	23,561	24,032	24,512	25,003
Revenues & gains in excess of expenses & losses	96,651	90,855	56,291	32,194	118,229	132,035	156,267	166,086
Other non-operating items:								
Discontinued operations	(4,484)	(26,639)	(2,720)	-	-	-	-	-
Income attributable to non-controlling interest	(7,728)	(9,826)	(15,046)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Total other non-operating operations	(12,212)	(36,465)	(17,765)	(14,483)	(14,999)	(15,054)	(15,099)	(15,133)
Revenues & gains in excess of expenses & losses attributable to \$	\$ 84,439	\$ 54,390	\$ 38,526	\$ 17,711	\$ 103,230	\$ 116,980	\$ 141,168	\$ 150,953
Uses expense related to COPA, excluding D&A expense	-	-	-	-	(10,750)	(27,250)	(43,500)	(49,000)
Net income, including COPA uses attributable to NewCo.	\$ 84,439	\$ 54,390	\$ 38,526	\$ 17,711	\$ 92,480	\$ 89,730	\$ 97,668	\$ 101,953

Balance Sheet - NewCo with Preliminary Efficiency Estimates								
\$'000s	Actuals			Forecasted				
	6/30/13	6/30/14	6/30/15	Year 1	Year 2	Year 3	Year 4	Year 5
Current assets:								
Cash & cash equivalents	\$ 130,860	\$ 89,859	\$ 128,580	\$ 99,994	\$ 115,197	\$ 91,247	\$ 93,168	\$ 135,397
Current portion of investments	25,447	28,262	22,904	22,904	22,904	22,904	22,904	22,904
Patient accounts receivable, net	271,216	278,583	274,678	273,154	284,303	289,989	295,789	301,704
Other receivables, net	51,463	60,187	41,588	43,667	45,851	48,143	50,551	53,078
Inventories & prepaid expenses	58,383	59,859	63,930	61,664	60,169	60,589	60,876	61,367
Total current assets	537,370	516,750	531,680	501,384	528,424	512,873	523,287	574,452
Other non-current assets:								
Long-term investments	1,037,563	1,124,957	1,154,927	1,178,026	1,201,586	1,225,618	1,250,131	1,275,133
Property, plant, & equipment, net	1,359,023	1,374,010	1,331,657	1,330,150	1,360,750	1,420,720	1,468,311	1,480,046
Goodwill	169,487	208,262	208,179	208,179	208,179	208,179	208,179	208,179
Net deferred financing, acquisition costs & other charges	33,658	30,067	28,972	27,523	26,147	24,840	23,598	22,418
Other assets	47,091	48,870	53,567	55,174	56,830	58,534	60,290	62,099
Total other non-current assets	2,646,822	2,786,166	2,777,303	2,799,052	2,853,492	2,937,891	3,010,509	3,047,875
Total assets	3,184,192	3,302,916	3,308,983	3,300,436	3,381,916	3,450,764	3,533,796	3,622,327
Current liabilities:								
Current portion of debt & liabilities	75,323	73,791	84,731	84,731	84,731	84,731	84,731	84,731
Accounts payable & accrued expenses	242,267	261,554	270,782	268,682	275,199	280,683	286,301	292,056
Estimated third-party payor settlements	33,932	18,888	18,471	18,841	19,217	19,602	19,994	20,394
Total current liabilities	351,523	354,233	373,985	372,254	379,148	385,017	391,027	397,181
Non-current liabilities:								
Long-term debt & liabilities	1,566,294	1,565,512	1,524,098	1,483,455	1,443,897	1,405,393	1,367,915	1,331,438
Retention bonus liability	-	-	-	-	5,000	-	-	-
Other long-term liabilities	78,447	99,400	81,633	83,265	84,931	86,629	88,362	90,129
Total non-current liabilities	1,644,740	1,664,912	1,605,731	1,566,721	1,533,827	1,492,022	1,456,277	1,421,567
Total liabilities	1,996,263	2,019,145	1,979,715	1,938,975	1,912,975	1,877,038	1,847,304	1,818,748
Net assets:								
Unrestricted	994,348	1,080,586	1,112,232	1,129,943	1,222,424	1,312,154	1,409,822	1,511,775
Temporarily restricted	19,703	20,418	20,508	20,508	20,508	20,508	20,508	20,508
Permanently restricted	1,438	1,446	1,450	1,450	1,450	1,450	1,450	1,450
Noncontrolling interests	172,439	181,321	195,078	209,560	224,559	239,614	254,713	269,846
Total net assets	1,187,929	1,283,771	1,329,268	1,361,462	1,468,941	1,573,725	1,686,493	1,803,579
Total liabilities and net assets	\$3,184,192	\$3,302,916	\$3,308,983	\$ 3,300,436	\$ 3,381,916	\$ 3,450,764	\$ 3,533,796	\$ 3,622,327

Statement of Cash Flows - NewCo with Preliminary Estimated Efficiencies		Forecasted				
		Year 1	Year 2	Year 3	Year 4	Year 5
\$'000s	Scenario					
Cash flows from operating activities:						
Income from operations		\$ 9,095	\$ 94,669	\$ 108,003	\$ 131,755	\$ 141,083
Uses expense related to COPA, excluding D&A expense		-	(10,750)	(27,250)	(43,500)	(49,000)
		9,095	83,919	80,753	88,255	92,083
Adjustments to reconcile change in net assets to net cash provided by operating activities:						
Depreciation and amortization		126,507	130,650	142,843	157,111	165,204
Loss on extinguishment of debt		-	-	-	-	-
Change in estimated fair value of derivatives		-	-	-	-	-
Equity in net income of JVs, net		-	-	-	-	-
Loss/(Gain) on disposal of assets		-	-	-	-	-
Capital Appreciation Bond accretion and other		-	-	-	-	-
Restricted contributions		-	-	-	-	-
Pension and other defined benefit plan adjustments		-	-	-	-	-
Increase/(Decrease) in cash due to change in:						
Patient accounts receivable, net		1,524	(11,149)	(5,686)	(5,800)	(5,916)
Other receivables, net		(2,079)	(2,183)	(2,293)	(2,407)	(2,528)
Inventories & prepaid expenses		2,266	1,496	(420)	(287)	(491)
Net deferred financing, acquisition costs & other charges		1,449	1,376	1,307	1,242	1,180
Other assets		(1,607)	(1,655)	(1,705)	(1,756)	(1,809)
Current portion of debt & liabilities		-	-	-	-	-
Accounts payable & accrued expenses		(2,100)	6,517	5,485	5,618	5,755
Estimated third-party payor settlements		369	377	384	392	400
Retention bonus liability		-	5,000	(5,000)	-	-
Other long-term liabilities		1,633	1,665	1,699	1,733	1,767
Total adjustments		127,962	132,093	136,614	155,846	163,562
Net cash provided by operating activities		137,057	216,011	217,367	244,101	255,646
Cash flows from investing activities:						
Purchases of property, plant, and equipment		(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Acquisitions, net of cash acquired		-	-	-	-	-
Non-operating gains, net		23,099	23,561	24,032	24,512	25,003
Purchases of held-to-maturity securities		(23,099)	(23,561)	(24,032)	(24,512)	(25,003)
Net distribution from JV's and unconsolidated affiliates		-	-	-	-	-
Proceeds from sale of plant, property, and equipment		-	-	-	-	-
Net cash used in investing activities		(125,000)	(161,250)	(202,813)	(204,703)	(176,938)
Cash flows from financing activities:						
Payments on LT debt and liabilities, including escrow deposits		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Payment of acquisition and financing costs		-	-	-	-	-
Proceeds from issuance of LT debt & other financings		-	-	-	-	-
Income attributable to non-controlling interest		-	-	-	-	-
Net amounts received on interest rate swaps		-	-	-	-	-
Restricted contributions received		-	-	-	-	-
Net cash used by financing activities		(40,643)	(39,559)	(38,504)	(37,477)	(36,478)
Net increase/(decrease) in cash and cash equivalents		(28,585)	15,202	(23,949)	1,920	42,230
Cash and cash equivalents at beginning of year		128,580	99,994	115,197	91,247	93,168
Cash and cash equivalents at end of year		\$ 99,994	\$ 115,197	\$ 91,247	\$ 93,168	\$ 135,397

CLAIRE COWART HALTOM, SHAREHOLDER
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E-Mail Address: chaltom@bakerdonelson.com

July 13, 2016

Via Email and Hand Delivery

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Response to Tennessee Department of Health Request for Information (#2) dated April 22, 2016

Dear Allison:

Enclosed please find a response to each of the additional documents/information requested by your office on April 22, 2016 from Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont").

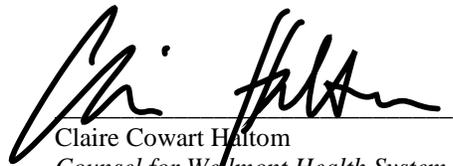
Please note that some of the documents responsive to your request contain confidential and proprietary information. In each such instance, the response contains the following parenthetical notation: "(considered confidential information and will be subsequently filed)." Mountain States and Wellmont will each submit a letter to the Tennessee Attorney General's Office requesting confidential treatment for their respective documents identified with this parenthetical.

Mountain States and Wellmont appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Thank you for your assistance.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC



Claire Cowart Haltom
Counsel for Wellmont Health System

Enclosure

cc: Jane Young, Esq.
Jeff Ockerman, Esq.
Janet Kleinfelter, Esq.
Vic Domen, Esq.
Gary Miller, Esq.
Tim Belisle, Esq.
Robert E. Cooper, Jr., Esq.
J. Richard Lodge, Esq.
Richard G. Cowart, Esq.

SUPPLEMENT TO RESPONSES TO QUESTIONS
SUBMITTED APRIL 22, 2016
BY
TENNESSEE DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR A CERTIFICATE OF PUBLIC ADVANTAGE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: July 25, 2016

Additional Request from the Department of Health
Submitted April 22, 2016

Mountain States Health Alliance and Wellmont Health System Response

I. INCOMPLETE (1)

a. Services Offered by Other Providers

Tenn. Comp. R. & Regs. 1200-38-01-. 02(2)(a)8

Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:

iii. **Provide information on the structure of physician practices to calculate the appropriate market share.¹**

RESPONSE: Information on the structure of physician practices is attached as Exhibit 3. The Parties have attempted to identify physicians by employment status (employed versus independent), and to aggregate physicians into their relevant practice groups. The Parties reiterate the difficulty calculating data for independent physicians:

- There is little publicly reported, and therefore available, data for outpatient services. Inpatient volumes are reported to the Tennessee Hospital Association for purposes of market share calculation, but the calculation of comparable market share measures for physician practice volumes is not possible because those volumes are not uniformly reported to an independent resource.
- The geographic scope of service for many physician specialties goes well beyond counties and prescribed geographic areas. For example, some advanced specialties may serve very broad service areas, and patients may travel out of the area to see specialists for services that could be obtained in locations near the Parties' three tertiary facilities. As a result, shares at the county level, or even at the service area level, may overstate concentration and competitive concerns.

As a result, share data in Exhibit 3 are provided based on counts of physicians, and allocating physicians to independent groups, which account for a large proportion of physicians in the Geographic Service Area. The Parties have made their best efforts to calculate independent physician services based on the limited publicly available data and their general industry knowledge of the region's health care providers.

Since the time the Application was submitted in February to today, a number of Wellmont employed and MSHA employed and affiliated physicians have been

¹ The market power of a single physician is not equal to the bargaining power of a physician group. Therefore, in Exhibit 6.1-E, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required.

hired, have left employment, and have retired. The information included in Exhibit 3 reflects the most current information available to the Parties. To reflect the changes in employment and affiliation that have occurred since February, the Parties have included in this Response an updated Exhibit 6.1E to the original Application for reference.

INDEX OF DOCUMENTS:

- Exhibit 3 - Information on the Structure of Physician Practices

REPLACEMENT OF EXHIBIT 6.1 (SECTION E) TO ORIGINAL APPLICATION DATED FEBRUARY 16, 2016

The Parties submit attached **Application Exhibit 6.1 (Section E)** as a replacement for **Application Exhibit 6.1 (Section E)** submitted with the original Application on February 16, 2016. The updates reflect the changes in employment and affiliation of physicians with Wellmont and Mountain States since February 2016 and the Parties' ongoing efforts to calculate physician data as accurately as possible.

INDEX OF DOCUMENTS:

- Updated Exhibit 6.1E to the Original COPA Application Dated February 16, 2016

Exhibit 3
Information on the Structure of Physician Practices

Exhibit 3A. Number of Providers by Practice Group for Wellmont and Mountain States

Group	WHS Employed	MSHA Employed	MSHA Affiliated*	MSHA Total	County or Counties
WELLMONT MEDICAL ASSOCIATES	269				Hawkins, Sullivan and Washington in Tennessee and Bristol, Lee, Norton City, Russell, Washington, and Wise in Virginia
WELLMONT CARDIOLOGY SERVICES	71				Carter, Greene, Hawkins, Sullivan and Washington in Tennessee and Russell, Washington, and Wythe in Virginia
MOUNTAIN STATES MEDICAL GROUP		296	58	354	Carter, Johnson, Sullivan, Unicoi, Washington in Tennessee and Russell, Smythe, Washington, Wise, and Wythe in Virginia
ABINGDON PHYSICIAN PARTNERS		2	20	22	Washington in Virginia
NORTON COMMUNITY PHYSICIAN SERVICES		1	20	21	Dickenson and Wise in Virginia

*Mountain States Affiliated physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Exhibit 3B. Number of Providers by Practice Group for Independent Groups

Group Name	Number of Physicians	County or Counties*
ETSU PHYSICIANS & ASSOCIATES	100 or more	Carter, Hancock, Sullivan, and Washington in Tennessee
HOLSTON MEDICAL GROUP	100 or more	Hawkins and Sullivan in Tennessee and Scott and Washington in Virginia
APPALACHIAN EMERGENCY PHYSICIANS	100 or more	Carter and Washington in Tennessee
STATE OF FRANKLIN HEALTHCARE ASSOCIATES	50-99	Carter and Washington in Tennessee
INPATIENT CONSULTANTS OF TENNESSEE	50-99	Knox and Washington in Tennessee and Washington in Virginia
MEDICAL CARE PLLC	26-49	Carter and Washington in Tennessee
VALLEY EMERGENCY PHYSICIANS	26-49	Smyth and Washington in Virginia
NORTHEAST TN EMERGENCY PHYSICIANS	26-49	Hancock, Hawkins, and Sullivan in Tennessee and Norton City and Wise in Virginia
BLUE RIDGE RADIOLOGY	26-49	Sullivan in Tennessee
HEALTHSTAR PHYSICIANS	26-49	Cocke, Hamblen, Jefferson, and Knox in Tennessee
APPALACHIAN ORTHOPEDICS ASSOCIATES PC	10-25	Washington in Tennessee
APPALACHIAN ORTHOPEDICS OF KINGSFORT	10-25	Sullivan in Tennessee
MOUNTAIN EMPIRE RADIOLOGY PC	10-25	Washington in Tennessee
WATAUGA ORTHOPEDICS PLC	10-25	Sullivan and Washington in Tennessee
CLINCH VALLEY PHYSICIANS INC	10-25	Tazewell in Virginia
EAST TENNESSEE BRAIN AND SPINE CENTER	10-25	Sullivan and Washington in Tennessee
GASTROENTEROLOGY ASSOCIATES	10-25	Sullivan in Tennessee and Washington and Wise in Virginia
MOUNTAIN REGION FAMILY MEDICINE	10-25	Sullivan in Tennessee and Scott in Virginia
DERMATOLOGY ASSOCIATES	10-25	Sullivan and Washington in Tennessee
MORRISTOWN-HAMBLEN HEALTH SYSTEM	10-25	Hamblen in Tennessee
BRISTOL ANESTHESIA SERVICES	10-25	Sullivan in Tennessee
CLINCH VALLEY MEDICAL CENTER	10-25	Tazewell in Virginia
ANESTHESIA AND PAIN CONSULTANTS	10-25	Washington in Tennessee
CLINCH VALLEY PHYSICIANS	10-25	Tazewell in Virginia
WATAUGA PATHOLOGY ASSOCIATES	10-25	Washington in Tennessee

Group Name	Number of Physicians	County or Counties*
WYTHE COUNTY COMMUNITY HOSPITAL	10-25	Wythe in Virginia
HIGHLANDS PATHOLOGY	10-25	Sullivan in Tennessee
52 INDEPENDENT GROUPS	5-9	Multiple Counties
416 INDEPENDENT GROUPS	1-4	Multiple Counties
185 PHYSICIANS WITH UNKNOWN AFFILIATION	1	Multiple Counties

Note: A large number of physicians had no known practice group affiliation; these are shown as one entry with "UNKNOWN GROUP."

* Counties are based on the locations identified by each practice's website. In some cases, these counties may only reflect the office address or billing address of the practice which does not account for outreach and/or facility credentialing. This is particularly true for hospital-based practices.

Updated Exhibit 6.1E
Physician Status by Specialty/Employment as of July 1, 2016

Data were developed by specialty to identify physicians employed by Wellmont, employed by Mountain States (or affiliated with Mountain States) and independent physicians. Data on independent physicians were developed using names and specialties for physicians with admitting privileges at Wellmont and/or Mountain States hospitals. The Overlap Flag identifies specialties in which both systems employed physicians.

Specialty*	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliated**
Grand Total (Overlap/Non-Overlap)		2,913	74.7%	11.7%	10.3%	3.4%
ORTHOPEDECS	X	135	85.9%	1.5%	11.1%	1.5%
OTHER SPECIALTIES	X	269	85.1%	6.7%	6.7%	1.5%
PEDIATRICS & NEONATOLOGY	X	177	84.7%	3.4%	4.0%	7.9%
OBSTETRICS & GYNECOLOGY	X	116	80.2%	5.2%	11.2%	3.4%
PRIMARY CARE	X	794	77.3%	15.9%	4.4%	2.4%
NEUROSCIENCES	X	73	76.7%	6.8%	12.3%	4.1%
GENERAL SURGERY	X	115	70.4%	3.5%	12.2%	13.9%
ENDOCRINOLOGY, DIABETES & METABOLISM	X	13	69.2%	23.1%	7.7%	0.0%
PSYCHIATRY, PSYCHOLOGY & SOCIAL SERVICES	X	80	66.3%	8.7%	22.5%	2.5%
HOSPITALIST	X	275	53.1%	17.1%	25.5%	4.4%
ONCOLOGY & HEMATOLOGY	X	76	51.3%	27.6%	10.5%	10.5%
PULMONOLOGY	X	44	43.2%	38.6%	11.4%	6.8%
URGENT CARE	X	104	36.5%	6.7%	49.0%	7.7%
CARDIOVASCULAR	X	146	34.2%	47.3%	17.8%	0.7%
RADIOLOGY		74	100.0%	0.0%	0.0%	0.0%
RHEUMATOLOGY		16	100.0%	0.0%	0.0%	0.0%
PATHOLOGY & LABORATORY MEDICINE		31	100.0%	0.0%	0.0%	0.0%
EMERGENCY MEDICINE		236	98.3%	0.0%	0.8%	0.8%
ENT		25	96.0%	4.0%	0.0%	0.0%
GASTROENTEROLOGY		55	94.5%	0.0%	5.5%	0.0%
NEPHROLOGY		16	93.8%	0.0%	6.3%	0.0%
PHYSICAL MEDICINE & REHABILITATION		14	92.9%	7.1%	0.0%	0.0%
UROLOGY		29	89.7%	0.0%	10.3%	0.0%

* The Specialty categories included in this table may differ slightly from those included in the original COPA application. The information available to the parties on employed, affiliated and independent physicians in the area utilize different categories of specialties (e.g. Family Medicine may be a specialty category in one list and Primary Care may be a specialty category in another list). The individual categories were aggregated to ensure specialties from various data sources could be combined to provide shares.

**Mountain States Affiliated physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

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July 25, 2016

Via Email and Hand Delivery

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Supplement to Responses to Tennessee Department of Health Request for Information (#2) dated April 22, 2016

Dear Allison:

Enclosed please find the response to Item I(a)(iii) requested by your office on April 22, 2016 from Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont"). As noted in the July 13th submission, the parties have calculated the appropriate market share for physician practices as requested. The parties believe this completes the Request for Information (#2) with the exception of those items that will be submitted to the Attorney General's office under separate cover.

Mountain States and Wellmont appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Thank you for your assistance.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC



Claire Cowart Haltom
Counsel for Wellmont Health System

Enclosure

cc: Jane Young, Esq.
Jeff Ockerman, Esq.
Janet Kleinfelter, Esq.

Vic Domen, Esq.
Gary Miller, Esq.
Tim Belisle, Esq.
Robert E. Cooper, Jr., Esq.
J. Richard Lodge, Esq.
Richard G. Cowart, Esq.

Revised Plan of Separation
between
Wellmont Health System
and
Mountain States Health Alliance

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Revised Plan of Separation (“the Revised Plan”) is prepared as part of the application for Certificate of Public Advantage (“COPA”) submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively “the Parties”) to the Tennessee Department of Health (“the Department”). The Revised Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the “New Health System”) in the event that the Department determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

1. Overview. The purpose of this outline is to comply with Tenn. Comp. Rules & Regulations 1200-38-01-.02(2)(a)(17). The Revised Plan will be described in two scenarios: the "Short-Term Period" (0 to 18 months) and the "Long-Term Period" (after 18 months).
2. Short-Term Period Plan of Separation. (0 to 18 months post-closing)
 - A. Overview. Re-establish a competitive dynamic by returning assets and operations to the control of the contributing party.
 - B. Assets Held Separate. Mountain States and Wellmont will not, during the Short-Term Period, transfer to the other, or to the New Health System, any Material Operating Assets held by either Mountain States or Wellmont prior to the affiliation. For purposes of this commitment, “Material Operating Assets” shall mean those assets that exceed 10% of the New Health System's total assets or roughly \$300 million. Assets used in providing support services to Mountain States and Wellmont may be transferred as appropriate to effect the integration and achieve cost savings and performance improvement.
 - C. The Process. Upon written notice from the Department that the COPA has been terminated, the following would occur:
 - (1) Preservation of Business. The New Health System will take all actions necessary to maintain the independent viability and competitiveness of Mountain States and Wellmont pending separation.
 - (2) Governance. The New Health System's Board of Directors will oversee the plan of separation to insure that the plan is successfully implemented, minimizing to the extent possible disputes between the separating entities and

disruptions in operations. Upon implementation of the plan of separation, the New Health System will be removed as member of Mountain States and Wellmont. Mountain States and Wellmont will return as the parent corporations of the pre-combination entities:

- a) Mountain States. Mountain States directors will resign from the Wellmont Board and the New Health System Board. Mountain States directors will appoint additional directors to the Mountain States Board.
- b) Wellmont. Wellmont directors will resign from the Mountain States Board and the New Health System Board. Wellmont directors will appoint additional directors to the Wellmont Board.

(3) Management.

- a) The Executive Chair/President of the New Health System will be named the Chief Executive Officer of Mountain States.
- b) The Chief Executive Officer of the New Health System will be named the Chief Executive Officer of Wellmont.
- c) Mountain States and Wellmont will appoint other executive officers of the respective corporations pursuant to established corporate procedures.
- d) Clinical Managers will be assigned to the Mountain States/Wellmont Clinical Site that is the Manager's principal place of service.

(4) Financial. Mountain States and Wellmont will become separate financial enterprises.

- a) Debt. Any debt issued by the New Health System will be allocated to Mountain States and Wellmont based upon the proportion of pre-merger debt that each brought to the merger, except that if the proceeds of any debt issued by the New Health System have been used to benefit a facility or facilities (e.g, debt proceeds used to expand physical plant), such debt will be allocated to the entity which receives that facility in the separation.
- b) Reserves. The cash and marketable securities of the New Health System will be separated between Mountain States and Wellmont in proportion to the original contribution at closing.

(5) Employees. The New Health System employees will be assigned to their principal place of business. Clinical employees will be assigned to the

Mountain States/Wellmont site that is the employee's principal place of service.

- (6) Employee Benefits. To the extent employee benefit plans have been combined, a plan of separation addressing employee benefits will be submitted. Each of Mountain States and Wellmont will be free to change or modify plans under separation. Mountain States and Wellmont will provide all legacy employees with credit for their New Health System service.
- (7) Clinical Services. During the Short-Term Period, the New Health System expects the consolidation of any significant clinical services to be limited. To the extent clinical services are combined, a plan of separation addressing clinical services, including a transition services agreement, will be submitted to the Tennessee Department of Health for information prior to such combination.
- (8) Information Technology. During the Short-Term Period, the New Health System will develop a combined approach to information technology. While planning and implementation are expected to begin, it is not anticipated that the Common Clinical IT Platform will be fully implemented in the Short-Term Period. Mountain States/Wellmont will each establish separate information technology services as part of the plan of separation. Transition services agreements will be utilized to assure no interruption in operations for Mountain States or Wellmont post-separation.
- (9) Payers. During the Short-Term Period, the New Health System expects to negotiate payer agreements consistent with the terms and provisions of the COPA. In the event of any separation of the New Health System during the Short-Term Period, both Mountain States and Wellmont will honor the provisions of the New Health System payer agreements for the balance of any base term (without renewals). If any payer wishes to modify or replace its New Health System payer agreement, Mountain States and Wellmont will negotiate in good faith to reach a mutually acceptable modified or new agreement. All future payer agreements will be negotiated separately by Mountain States and Wellmont.
- (10) Physicians. During the Short-Term Period, the New Health System expects to plan, but not execute, a combination of its physician enterprises. To the extent any physician services are combined, a plan of separation addressing physician services, including actions to return physician and other clinic employees to the Mountain States or Wellmont entity that was his or her employer at the closing, will be submitted to the Tennessee Department of Health for information prior to action. Hospital-based physician contracts, such as radiology, pathology, anesthesia, hospitalists,

and emergency medicine shall be assigned to the site of service. Mountain States and Wellmont shall honor the physician contracts for the remainder of the base terms (without renewals).

- (11) Dissolution. Once Mountain States and Wellmont no longer require support services from the New Health System, the Board of Directors of the New Health System will follow the procedures for voluntary dissolution of the New Health System as provided by Tennessee law.

3. Long-Term Period Plan of Separation. (after 18 months post-closing)

A. Overview. The Long-Term Period plan of separation would be implemented if the Department terminates the COPA after determining that the benefits of the merger no longer outweigh the disadvantages by clear and convincing evidence. Due to the difficulty of predicting the health care environment in the long term, the Long-Term Period plan of separation of necessity is a description of a process for deciding how to separate the assets and operations of the New Health System.

B. The Process:

- (1) Upon receipt of written notice from the Department that the COPA has been terminated, the New Health System will retain a qualified consultant (“the Consultant”).
- (2) The Consultant will assist the New Health System in complying with the written notice that the COPA has been terminated by analyzing competitive conditions in the markets subject to the Department’s written notice and identifying the specific steps necessary to return the subject markets to a competitive state.
- (3) The New Health System will submit a plan of separation to the Department (the “Proposed Plan). The Proposed Plan will address each of the substantive elements required of a Short-Term Period plan of separation and will be accompanied by a written report from the Consultant concerning the suitability of the Proposed Plan in addressing the competitive deficiencies that resulted in the termination of the COPA.
- (4) The Proposed Plan shall be submitted within 180 days of receipt of written notice from the Department that the COPA has been terminated. The Proposed Plan shall include a timetable for action which shall be approved by the Department.

C. Upon the Department’s approval of the Proposed Plan (or of any plan that contains revisions thereto) (the “Final Plan”), the New Health System will implement the Final Plan within the timetable prescribed in the Final Plan.

D. The Final Plan will provide that the Department may require that an independent third-party health care expert serve as a monitor (“the Monitor”) to oversee the

process of implementing the Final Plan. The New Health System will pay the fees and expenses of the Monitor.

4. Non-Exclusive Plan. To the extent the Parties or the New Health System reasonably determines (based upon the current facts and circumstances) that a competitive dynamic may be restored in another, more efficient or effective means, the Parties or the New Health System may submit a new plan of separation different from the pre-submitted plan. In such event, the amended plan of separation must receive the Department's approval prior to its implementation.
5. Annual Update. Department regulations provide that the plan of separation be updated annually. The annual update will address each of the following elements as appropriate and possible in light of the then existing facts and circumstances: (a) Governance, (b) Management, (c) Financial Separation, (d) Employees, (e) Employee Benefits, (f) Clinical Services, (g) Information Technology, (h) Payers, and (i) Physicians.

CLAIRE COWART HALTOM, SHAREHOLDER
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September 9, 2016

Via Email and Hand Delivery

Allison Thigpen Rajaratnam, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Response to Tennessee Department of Health Request for Additional Information (#1) dated
March 28, 2016

Dear Allison:

Enclosed please find a revised plan of separation requested by your office on March 28, 2016 from
Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont").

Mountain States and Wellmont appreciate the opportunity to provide the Department with additional
information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of
this information or any questions that you, or your colleagues, may have.

Thank you for your assistance.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC



Claire Cowart Haltom
Counsel for Wellmont Health System

Enclosure

cc: Jane Young, Esq.
Jeff Ockerman, Esq.
Janet Kleinfelter, Esq.
Vic Domen, Esq.
Gary Miller, Esq.
Tim Belisle, Esq.

Robert E. Cooper, Jr., Esq.
J. Richard Lodge, Esq.
Richard G. Cowart, Esq.

EXECUTION COPY

**First Amendment to
Master Affiliation Agreement
and
Plan of Integration**

By and Between

**Wellmont Health System
and
Mountain States Health Alliance**

Dated as of September 8, 2016

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EXECUTION COPY

THIS FIRST AMENDMENT TO MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "First Amendment") is dated as of September 8, 2016, by and between Wellmont Health System, a Tennessee nonprofit public benefit corporation with a principal place of business in Kingsport, Tennessee ("Wellmont") and Mountain States Health Alliance, a Tennessee nonprofit public benefit corporation with a principal place of business in Johnson City, Tennessee ("MSHA"). Wellmont and MSHA are each a "Party" and collectively the "Parties."

WHEREAS, the Parties have entered into the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016 (the "Agreement"); and

WHEREAS, the Parties have agreed to amend certain provisions of the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the representations, warranties, premises and the mutual covenants and agreements hereinafter contained, each of the parties hereto, intending to be legally bound, hereby agree as follows:

Article I. Amendments.

Section 1.01 Exhibits C-2 and F. Exhibit C-2 (Interim Officers) and Exhibit F (Integration Council) are deleted in their entirety and replaced with the correspondingly labeled Exhibits attached hereto.

Section 1.02 Cooperative Agreement. Section 5.06(a) of the Agreement is amended to read in its entirety as follows:

(a) The Parties deem this Agreement to be their "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993, as amended (the "Tennessee COPA Act") and § 15.2-5369 of the Code of Virginia (the "Virginia COPA Act" and together with Tennessee COPA Act, the "COPA Acts"). Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties hereby agree upon and incorporate the terms contained in Exhibit H as part of this "cooperative agreement."

Section 1.03 Exhibit H. The Agreement is amended by adding a new Exhibit H as labeled and attached hereto.

Section 1.04 Amendment, No Further Modification. The Parties agree that this First Amendment is an effective and binding amendment of the Agreement pursuant to Section 10.07 of the Agreement. Except as otherwise expressly stated in this First Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect, without amendment or modification.

Section 1.05 Capitalized Terms. Capitalized terms used but not otherwise defined herein shall have the same meaning ascribed to such terms in the Agreement.

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Section 1.06 Execution in Counterparts. This First Amendment may be executed in more than one counterpart, each of which shall be deemed to be an original, but all of which shall be deemed to constitute one instrument. It shall not be necessary for all parties to have signed the same counterpart provided that all parties have signed at least one counterpart.

[Signature page follows]

EXECUTION COPY

IN WITNESS WHEREOF, the parties hereto have executed or caused to be executed this First Amendment on the day and year first above written.

WELLMONT HEALTH SYSTEM

By:



Roger Leonard
Chairman of the Board of Directors



Bart Hove
President and Chief Executive Officer

MOUNTAIN STATES HEALTH ALLIANCE

By:



Barbara Allen
Chairman of the Board of Directors



Alan Levine
President and Chief Executive Officer

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EXHIBITS

Exhibit C-2. Interim Directors and Interim Officers.

Exhibit F. Integration Council

Exhibit H. Cooperative Agreement Terms

EXECUTION COPY

EXHIBIT C-2
Interim Directors and Interim Officers

Directors:

Barbara Allen

Roger Leonard

Roger Mowen

Gary Peacock

Officers:

President: Alan Levine

Secretary/Treasurer: Bart Hove

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EXHIBIT F
Integration Council

MSHA

Marvin Eichorn (Co-Chair)

Dr. Morris Seligman

Lynn Krutak

Tony Keck

Dr. Sandra Brooks

Tim Belisle

WHS

Eric Deaton (Co-Chair)

Todd Dougan

Dr. Robert Funke

Dr. Dale Sargent

Todd Norris

Gary Miller

EXHIBIT H

Cooperative Agreement Terms

Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties do hereby agree upon and incorporate the following terms as part of this Cooperative Agreement:

(e) **REQUEST**: A description of the competitive environment in the parties’ geographic service area, including:

(i) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;

RESPONSE: The Parties intend for the Cooperative Agreement to include all services, products, and service locations under the control of Mountain States and Wellmont at the time of execution of the Cooperative Agreement and for so long as those entities remain under the control of the New Health System.

(ii) The parties’ estimate of their current market shares for services and products and the projected market shares if the COPA is granted;

RESPONSE: The Parties estimate their current share in the Geographic Service Area for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data¹ as follows:

Table 11.1 – Share of CY2014 Discharges, Current Systems²

System	Total	Share of Total Discharges
Mountain States	58,441	45.6%
Wellmont	35,075	27.4%
Other	34,584	27.0%

Table 11.1 identifies the percentage of total discharges in the Geographic Service Area (exclusive of DRG 795) that are accounted for by Mountain States, Wellmont, or other health care systems. Share analyses demonstrate that three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center, and Johnson City Medical Center) make up fifty-eight percent (58%) of the combined

¹ Shares of the Geographic Service Area and for general acute care inpatient services were calculated using CY2014 discharge data for all Tennessee and Virginia hospitals. Shares were calculated defining general acute care services excluding normal newborns (DRG 795) and including (excluding) MDC 19 (Mental Diseases) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). Tables detailing discharges by hospitals serving the Geographic Service Area, and hospitals in the Geographic Service Area, are in **Exhibit 5.2**.

² Shares for this table were calculated defining general acute care services excluding normal newborns (DRG 795).

system's discharges.³ Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

If the COPA is granted and volumes in the Geographic Service Area remain consistent with CY2014 trends, then the Parties estimate the projected shares for general acute care inpatient services would be as follows in **Table 11.2**:

Table 11.2 – Share of CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competitors	34,584	27.0%

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 11.3**⁴ provides share estimates for independent physicians, Wellmont, and Mountain States in the specialties in which there is an overlap. **Table 11.4** reports shares for specialties in which there is not an overlap – that is, where Mountain States and Wellmont do not each employ physicians.

³ These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.

⁴ **Tables 11.3** and **11.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at their hospitals and employed or affiliated physicians and the specialty of physicians.

Table 11.3 – Shares of Physicians in Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate ⁵
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
OB/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

⁵ Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate ⁶
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

⁶ Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System (Continued)

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)		2,142	70%	9%	17%	4%
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

A large number of independent providers of outpatient services compete in the Geographic Service Area. In many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. **Table 11.5⁷** depicts counts and share numbers for categories of outpatient services based on the affiliation of the providers:

⁷ **Table 11.5** depicts the counts and shares for categories of outpatient services and is based on a listing provided by the Parties of outpatient facilities by type including names, locations, and affiliations.

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS	Mountain	Mountain	Non-Managed		Total
	Combined %	States	NsCH Affiliate	Wellmont	Joint Venture	
Pharmacy	1.4%	5	0	0	0	349
Fitness Center	0.0%	0	0	0	0	98
XRAY	28.3%	14	0	12	0	66
Nursing Home	7.6%	3	0	2	0	61
Physical Therapy	6.6%	1	0	3	0	57
Home Health	16.7%	8	0	2	0	50
Rehabilitation	39.5%	9	0	8	0	26
CT	51.2%	12	0	10	0	21
MRI	43.9%	11	0	7	0	23
Surgery - Endoscopy	45.2%	9	0	5	0	17
Urgent Care	50.0%	8	0	8	0	16
Surgery - Hospital-based	46.7%	9	0	5	0	16
Dialysis Services	0.0%	0	0	0	0	25
Wellness Center	14.3%	2	0	1	0	18
Surgery - ASC	60.0%	2	0	3	4	6
Chemotherapy	55.6%	4	1	5	0	8
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11
Radiation Therapy	54.5%	3	0	3	0	5
Cancer Center	54.5%	3	0	3	0	5
Weight Loss Center	14.3%	0	0	1	0	6
Community Center	0.0%	0	0	0	0	6
Cancer Support Services	0.0%	0	0	0	0	1
Women's Cancer Services	100.0%	0	0	1	0	0

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

- (iii) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and

RESPONSE: The Parties acknowledge that the merger will eliminate competition between Wellmont and Mountain States in certain areas. The benefits of the merger will far outweigh this loss of competition, due to the cost-savings, quality enhancement and improved access the merger will generate. In addition, significant benefits will result from the Parties' commitments outlined herein, all of which will be actively supervised by the States. Moreover, the New Health System will face significant competition from the independent hospitals and other health care providers located in its service area, and, increasingly, from more distantly located health systems. With enhanced access to cost and quality information, patients utilize their mobility and often leave the immediate service area for health care services in locations including Nashville, Asheville, Knoxville and Winston Salem. The parties expect this pattern to increase.

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- (iv) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.

RESPONSE: No Certificate of Need will be required under the proposed Cooperative Agreement.

- (f) **REQUEST:** Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals.

RESPONSE: It is the objective of the New Health System to become one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. In order to achieve this objective, the Parties will conduct frequent employee and physician satisfaction and engagement assessments benchmarking with national organizations to achieve at least top quartile performance. The Parties will also build substantial partnerships beyond what currently exist with regional colleges and universities in Tennessee and Virginia that train physicians, nurses, and allied health professionals to ensure there is a strong pipeline of regional health professionals.

The Parties recognize that their workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for their team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success. The New Health System is committed to its existing workforce. Therefore, when the New Health System is formed:

COMMITMENTS

- The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.
- The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.
- The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

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The New Health System will achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by volume and varies across the market from time to time. Health care workers are in great demand in the region, and retaining and developing excellent health professionals in the region will be of utmost importance to ensure the highest clinical quality. Wages must remain competitive to attract top regional and national talent.

Further, significant investments must be made in the development of infrastructures and human resources for community health improvement, population health management, academics and research, and new high-level services. In addition to the significant ongoing base of clinical personnel, support staff, and physicians, all of these initiatives will serve to further develop the region's health care workforce and support the regional economy.

A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical center aligned in important ways with the New Health System in its efforts to transform health care delivery and to address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of an enhanced academic medical center to bring specific health care and economic benefits to the community. For example, the Parties, with their academic partners, plan to create new specialty fellowship training opportunities, build an expanded research infrastructure, add new medical and related faculty, and attract research funding, especially translational research, to address regional health improvement objectives. These efforts will benefit the community directly and indirectly, with expanded efforts to develop research specific to the local communities' health care needs and issues. The Parties intend for the enhanced academic medical center to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities with overall health and economic well-being.

In the current environment, Wellmont and Mountain States have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than \$85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, build and sustain research infrastructure, and add faculty. These are all critical to sustaining an

active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists. Specifically, the Parties commit to the following:

COMMITMENTS
<ul style="list-style-type: none">• With academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.• The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

(g) **REQUEST:** Description of financial performance, including:

- (i) A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five years including debt, bond rating and debt service and copies of external certified public accountants annual reports;

RESPONSE: See attached **Exhibit 11.4** for a description and summary of all aspects of the financial performance of Mountain States for the preceding five fiscal years. See attached **Exhibit 11.5** for a description and summary of all aspects of the financial performance of Wellmont for the preceding five fiscal years. The Mountain States Covenant Compliance Certificates (**Exhibit 11.4D**), the Mountain States Officer's Certificates accompanying Independent Auditor's Reports (**Exhibit 11.4E**), and the Wellmont External Auditor Management Letters (**Exhibit 11.5D**) are considered confidential information and will be subsequently filed.

- (ii) A copy of the current annual budget for each party to the Cooperative Agreement and a three year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;

RESPONSE: The current annual budgets for Mountain States (**Exhibit 11.6**) and Wellmont (**Exhibit 11.7**) are considered competitively sensitive information under federal antitrust laws and will be subsequently filed. A five-year projected budget for the New Health System is attached as **Exhibit 11.8**.

- (iii) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;
- I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

RESPONSE: Please see attached **Exhibit 11.9** identifying all insurance contracts and payer agreements in place at the time of the Application for Mountain States. Please see attached **Exhibit 11.10** identifying all insurance contracts and payer agreements in place at the time of the Application for Wellmont.

While some of the payer agreements held by both Parties permit the termination of the agreement by the payer upon a change of control, the Parties do not intend to amend their current insurance and payer agreements in connection with completing the affiliation except as set forth herein. Going forward, the Parties intend the New Health System will negotiate with the payers in the ordinary course of business as each managed care contract comes up for renewal after the Closing.

- II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties of the Cooperative Agreement, if the COPA is granted including changes in percentage of risk-bearing contracts;

RESPONSE: Like other health systems across Tennessee and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals. Wellmont and Mountain States each approach these negotiations with the basic goal of agreeing on rates and terms that will enable the health systems to cover the cost of providing high quality health care while earning a reasonable margin to invest in maintaining and improving their facilities and expand their service offerings.

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases,

which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.
- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients. Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

The Parties' intend to manage population health through the deployment of a research-based ten year plan that is focused on reducing the variables leading to chronic disease, improved clinical coordination, higher quality facilitated by the consolidation of services, and a shared information technology platform, among other things. All of these benefits strengthen the ability of the Parties to engage in risk-based contracting to a far greater extent than is currently the practice in the region. It is, therefore, the intent of the New Health System that future contractual arrangements with payers will be more focused on identification of the drivers of cost, with a shared objective of reducing unnecessary cost, and sharing the benefit of such successful initiatives.

III. The following policies:

- A. Policy that assures no restrictions to Medicare and/or Medicaid patients,
- B. Policies for free or reduced fee care for the uninsured and indigent,
- C. Policies for bad debt write-off; and
- D. Policies that assure parties to the Cooperative Agreement will maintain or exceed the existing level of charitable programs and services.

RESPONSE: Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid are housed within Mountain States. The New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. The current charity and other related policies for both Mountain States and Wellmont are attached as **Exhibits 8.3 and 8.4**. If the COPA is granted, the Parties intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Parties and consistent with the IRS's final 501(r) rules. As evidence of this commitment, the Parties have committed in the Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Parties.⁸ Specifically, the Parties intend to address each category of patients as follows:

⁸ See **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.
- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

IV. Identification of existing or future business plans, reports, studies or other documents of each party that:

- A. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and
- B. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.

RESPONSE: Information regarding existing and future business plans of Mountain States (**Exhibit 11.11**) and Wellmont (**Exhibit 11.12**) is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

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(h) **REQUEST:** A description of the plan to systematically integrate health care and preventive services among the parties to the Cooperative Agreement, in the proposed geographic service area, to address the following:

- (i) A streamlined management structure, including a description of a single board of directors, centralized leadership and operating structure;

RESPONSE: Please see response to 11.b above.

- (ii) Alignment of the care delivery decisions of the system with the interest of the community;

RESPONSE: A well-executed merger provides multiple opportunities to enhance care delivery and patient outcomes through the consolidation, integration, realignment and/or enhancement of clinical facilities and services (collectively the "Clinical Consolidation"). Clinical Consolidation can involve both concentration of services of a particular type in fewer locations and/or establishment of common protocols and systems across a common set of services with an ultimate goal of yielding improved outcomes, sustaining the most effective levels of services at the right locations, reducing costs of care, and related efficiencies. Where appropriate, these Clinical Consolidations are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered by a health care delivery system are continuously evaluated to ensure efficiency and the best outcome for patients.

As a means to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy that will allow the New Health System to utilize a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients and to make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 11.13**.

A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefit and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as those proposed by the New Health System and outlined in this Application.

(iii) Clinical standardization;

RESPONSE: A well-executed merger can also improve patient outcomes if it results in improved performance management processes to assist leaders in identifying where (and why) problems are occurring and how to implement best practices to coordinate care across the system. The New Health System is firmly committed to standardizing its management and clinical practice policies and procedures to promote efficiency and higher standards of care throughout the New Health System. As evidence of this commitment, the New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and financial information needed to integrate this process across the range of inpatient, outpatient, and physician services. The Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in **Section 8** herein. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

(iv) Alignment of cultural identities of the parties to the Cooperative Agreement; and

RESPONSE: There are many specific steps the Parties will take to align the cultural identities of the two organizations, including merging the executive leadership, establishing a board made up of equal representation from both legacy systems, agreeing on the appointment of new, independent board members with expertise in integration, implementation of a Clinical Council, bringing together key providers of both systems and implementing a single information technology platform that will be used to promote system-wide communication, cultural integration, and implement common clinical standards for improvement of patient quality.

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The New Health System's board of directors and management team will be composed of current executives from both Wellmont and Mountain States.

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.
- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who would not be incumbent members of either Party's board of directors.
- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU.
- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).
- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

Promptly after Closing, the New Health System will establish a physician-led Clinical Council (see **Section 8.A.iii**) to establish common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States.

As discussed in **Section 8.A.i**, the New Health System will adopt a Common Clinical IT Platform that will allow all providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care.

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer

competitive salaries, and combine the best of each hospital's career development programs as described more fully in **Section 11.f**.

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in **Section 8.A.iv**. This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

- (v) Implementation of risk-based payment models to include risk, a schedule of risk assumption and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

RESPONSE: Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients in a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.

The New Health System intends to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period. Additionally, the New Health System will commit to having at least one risk-based model in place within two years after Closing. No payer has historically expressed an interest in a global spending cap for hospital services in this region. However, after completing its clinical integration/alignment, the New Health System is willing to engage in those discussions if requested by a reputable payer, and assuming the New Health System is extended an actuarially sound proposal.

As further evidence of its commitment to move towards risk-based payment, the New Health System is willing to commit to the following:

COMMITMENTS

- For all Principal Payers,* the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system.
- Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

(i) **REQUEST**: A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement including:

- Proposed use of any cost savings to reduce prices borne by insurers and consumers;
- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term Population health improvements; and
- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: Funding the population health, access to care, enhanced health services, and other commitments described in this Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Parties have analyzed the anticipated efficiencies in three categories and calculated the following anticipated savings.

The Parties commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies. The economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three

was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are more fully discussed below.

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include
 - Harmonization to a Common Clinical IT platform
 - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
 - Reductions in unnecessary duplication of Call Pay
 - Reductions in Locum Tenens and use of "Registry Staff"
 - Renegotiations of service, maintenance, and other contracts
 - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
 - Added economies and efficiencies gained from the larger size of the New Health System.

The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately \$70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from

the merger in labor expenses totaling approximately \$25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. **Clinical Efficiencies.** The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies

generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

- Proposed use of any cost savings to reduce prices borne by insurers and consumers.

RESPONSE: To ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.
- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

RESPONSE: The New Health System is committed to improving community health through investment of not less than \$75 million over ten years in science

and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.
- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For

example, the Northeast region⁹ ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

⁹ The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. See <https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf> accessed February 4, 2016.

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least \$140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; develop community-based mental health resources such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Improving Health Care Value. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices which are described in more detail in this Application.

Investment in Health Research and Graduate Medical Education. The New Health System will commit not less than \$85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. These funds will enhance the Parties' academic partners' abilities to invest in additional research infrastructure, a significant benefit to the State of Tennessee and Commonwealth of Virginia. Additionally, partnerships with academic institutions in Tennessee and Virginia will enable research-based and academic approaches to the provision of the services the New Health System intends to invest to improve overall population health. These initiatives would not be sustainable in the region without the financial support created by the merger.

Avoidance of Duplication of Hospital Resources. Combining the region's two major health systems in an integrated delivery model is the best and most effective way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. These efforts will provide resources that can be invested in more value-based spending in the region –

spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

Improvements in Patient Outcomes. The region served by the Parties to the Cooperative Agreement faces significant health care challenges. In this environment, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes in the region. The New Health System will adopt a Common Clinical IT Platform to allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide, physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of up to \$150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over \$19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain hospital operations in these areas across the region to preserve and enhance access to quality care in these rural communities.

Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant

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gaps exist in the continuum of care related to these services. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems. The New Health System will invest in the development of new capacity for residential addiction treatment with the goal of reducing the incidence of addiction in our region.

- (j) **REQUEST**: Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. Measures should include source and projected trajectory over each of the first five years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:
- (i) Improvements in the service area population's health that exceed Measures of national and state improvement;
 - (ii) Continuity in availability of services throughout the service area;
 - (iii) Access and use of preventive and treatment health care services throughout the service area;
 - (iv) Operational savings projected to lower health care costs to payers and consumers; and
 - (v) Improvements in quality of services as defined by surveys of the Joint Commission.

RESPONSE: The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report finds that all Tennessee counties in the Geographic Service Area exceed the national average for smoking. The state level obesity rate exceeds the national average and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%). According to the same report, three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birth weight births and three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates. **Table 8.1** reports key statistics on the population of the counties in the Geographic Service Area, including metrics for obesity, smoking, death rates due to drug poisoning and childhood poverty.

The Parties share the State's concern about health disparities in the region and are aware of the acute challenges present in the individual counties across the Geographic Service Area. As a result, the Parties propose that ongoing evaluation of the Public Advantage resulting from the merger take into consideration the New Health System's pursuit of the Institute of Health Improvement's Triple Aim goals, commonly considered the national standard for evaluation of health care effectiveness. The Triple Aim objectives are to improve population health, improve patient experience of care (quality and access), and

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manage the per capita cost of health care. In this application, the Parties have organized the necessary actions by the New Health System to pursue the Triple Aim objectives as follows:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Research and Graduate Medical Education
- Attracting and Retaining a Strong Workforce

In order to evaluate the public benefit provided by the New Health System on a continuous basis, the Parties propose that the Department adopt an **Index of Public Advantage and Community Health Improvement** comprised of five major categories:

- A. Commitment to Improve Community Health
- B. Enhanced Health Care Services
- C. Expanding Access and Choice
- D. Improving Health Care Value: Managing Quality, Cost and Service
- E. Investment in Health Research/Education and Commitment to Workforce

A description of each category and the accountability mechanisms the Parties propose the State consider for each category are outlined in detail in the following sections.

A. Commitment to Improve Community Health

Community health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care. Because of the complex set of influences that shape community health and well-being, effective improvement strategies must be developed through a combination of evidence-based approaches and an understanding of local and regional culture, capacity and resources. Plans that are adopted “off the shelf” from elsewhere, without community buy-in and adaptation, have less chance of success. Although there are similarities with other parts of Tennessee and Virginia, the southern Appalachian mountain region of Northeast Tennessee and Southwest Virginia has a distinct culture, capacity and resource base that results in a unique set of health issues.

There are tremendously valuable assets, organizations and individuals highly motivated to address the underlying factors that affect the poor health status of our region. ETSU's College of Public Health and Quillen College of Medicine are both nationally recognized for their contributions to rural community health improvement, along with a host of other academic institutions throughout the region. In addition, municipalities, community organizations such as local United Way agencies and YMCAs, Healthy Kingsport, chambers of commerce, and health departments are highly motivated to work in new, focused ways to improve community health.

Much of the work and investment devoted to these efforts in the past, however, has

lacked unified focus in combination with sustainable funding. While the Parties believe that motivated leadership and substantial investment from the New Health System will be transformational, they also believe that a sustainable collective impact model of community health improvement stands the best chance of creating long-standing health improvements.

To make sustained improvements in health, a portfolio of investments, interventions and performance improvements designed to impact specific long-term goals at a variety of intervention and prevention levels is necessary. **Figure 11.1** depicts the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") process for community health improvement. MAPP suggests that it is critical for the New Health System, the State and local Departments of Health and the broad community of stakeholders to work together in an Accountable Care Community arrangement to formulate the appropriate investments, interventions and performance improvements to populate a robust and dynamic community health improvement portfolio. This process includes 1) defining a common vision and goals; 2) conducting comprehensive assessments of community health status and well as community and public health systems culture, capacity and resources; 3) prioritizing health issues; 4) formulating goals and strategies; and 5) evaluation and monitoring.

Figure 11.1 - Mobilizing for Action through Planning and Partnerships



Some progress has already been made. Several local, state and national analyses have identified the key health issues in our region and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed.

Additionally, in cooperation with the College of Public Health at ETSU, the Parties launched the region’s most substantial community health improvement assessment effort

in August. Four Community Health Work Groups have been created to specifically focus on medical needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. These workgroups are co-chaired by regional community leaders from both Tennessee and Virginia and are organized by Healthy Children and Families, Mental Health and Addiction, Population Health and Healthy Communities, and Research and Academics. The charters for these groups can be found in **Exhibit 8.2A**.

Analyzing the most current findings of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Southwest Virginia Blueprint for Health Improvement and Health-Enabled Prosperity, as well as initial feedback from the Community Health Work Groups organized by Mountain States and Wellmont, the Parties have identified five Key Focus Areas and several related Health Concerns in which the New Health System is committed to investing at least \$75 million over ten years in population health improvement.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.
- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.
- ***Improve Access to Behavioral Health Services*** through new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region; as well as community-based mental health resources, such as mental health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.

For the first category of the Index, the Parties propose an accountability mechanism for

the commitment to improve community health that the New Health System has set forth in this Application. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) in **Table 11.6**.

Table 11.6 - Proposed Commitment to Improve Community Health Measures

Index of Public Advantage and Community Health Improvement		
A. Commitment to Improve Community Health Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement.	Annual report to State attesting to progress towards compliance until \$75 million is invested.
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed-upon by the State and the New Health System in the COPA.	Commitment to Community Health Annual Report to State will attest to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.

In addition to the Commitment to Community Health Annual Report, described in more detail below, the Parties will submit a yearly report to the State attesting to progress toward the creation of a new integrated delivery system through investment of not less than \$75 million and an annual report to the State attesting to compliance with the quality reporting obligations as outlined in the COPA.

The annual report to the State attesting to progress on the achievement of accountability mechanisms for each Key Focus Area (the "Commitment to Community Health Annual Report") would be developed as follows:

Proposal for Development of the Commitment to Community Health Annual Report

- As part of the State's process to determine the Application's completeness, the Department and the Parties will agree on the Key Focus Areas of the commitment to improve community health.
- After the Application is deemed complete, and during the Application review period, the New Health System and the Department, with input from community stakeholders (including the Department's Advisory Groups) will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the State and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the COPA.

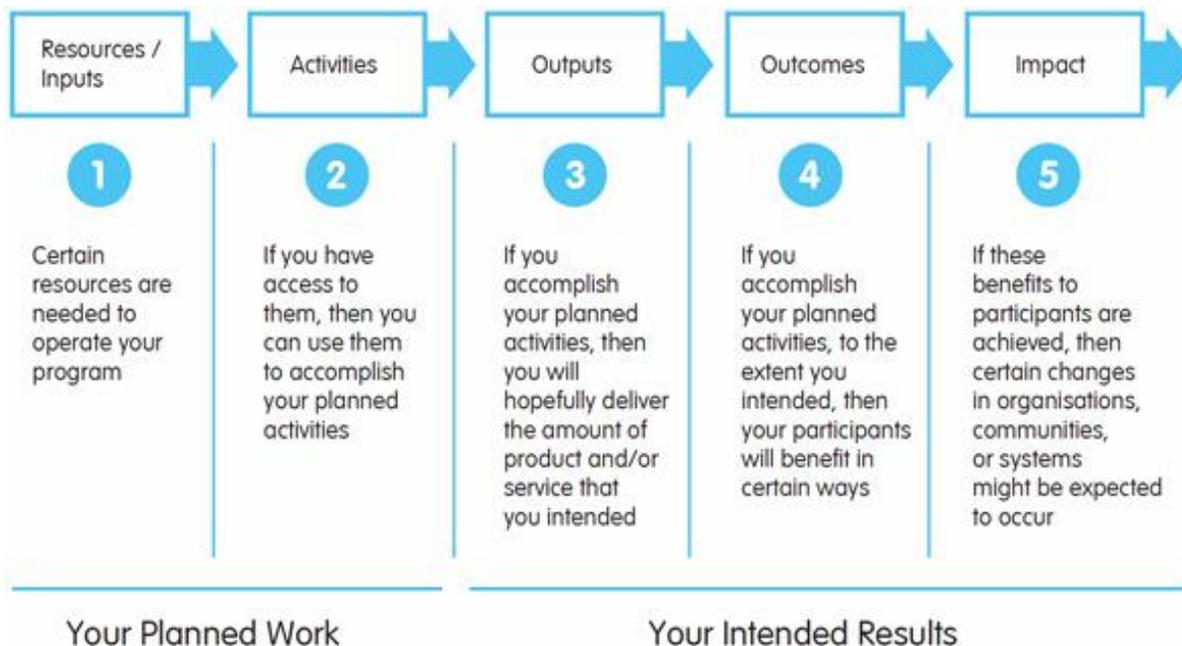
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- The COPA, if granted, will outline the specific Key Focus Areas, the individual Health Concerns, the Accountability Mechanisms, the Tracking Measures, and relevant baselines within each area agreed upon by the Department and the New Health System to be included in the Commitment to Community Health Annual Report.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in **Figure 11.2** for development of the Commitment to Community Health Annual Report Measures.

The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change occurring in organizations, communities or systems as a result of program activities often with longer-term time frames of 7 to 10 years.

Figure 11.2 - Logic Model for Evaluation



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Under this model the State could evaluate progress toward *long-term* community health improvement outcomes under the COPA by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The State and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).

Table 11.7 identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Parties propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Parties have identified specific Health Concerns (first column) that pose an important challenge and priority for health in this region; these are aligned with health challenges and priorities identified by the states. The second column identifies a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally.

Column Three provides a *representative* investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area.

The fourth (highlighted) column provides the relevant Accountability Mechanism the parties believe reflects the New Health System's performance related to the investment, intervention, or performance improvement.

Column Five provides a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern.¹⁰ The final two columns reference County level disparities as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

¹⁰ In addition to consideration of Triple Aim objectives, the Parties also have considered the categories of health measures for access, cost, health, and quality identified in the Institute of Medicine ("IOM") Vital Signs Core Measures; each of the several areas that these investment, intervention, or performance improvement would target are aligned with specific IOM Core Measures.

Table 11.7 - Sample Commitment to Community Health Annual Report

<i>Health Concern</i>	<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area¹¹</i>	
Key Focus Area #1: Ensure Strong Starts for Children							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties ¹²	Establish agreed- upon number of evidence-based Home Visitation Programs ¹³ in specific counties by set date	Percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs	Johnson, Carter, Cocke ¹⁴	Tazewell, Buchanan, Smyth ¹⁵
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with Neonatal Abstinence Syndrome	Establish residential treatment for pregnant woman with addiction in certain high-risk communities ¹⁶	Establish agreed-upon number of residential treatment programs for pregnant woman with addiction in specific counties by set date	Number of women in high-risk communities initiating residential treatment	Hancock, Hamblen, Hawkins ¹⁷	Dickenson, Wise, Tazewell, Buchanan ¹⁸

¹¹ This column is based on data that includes the Virginia counties and Independent Cities within the Geographic Service Area.

¹² This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,4,5,8, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

¹³ Nurse Family Partnership is one example of a Department of Health and Human Services “evidenced based early childhood home visitation service delivery model.” Nurse Family Partnership is designed for first-time, low-income mothers and their children, from during pregnancy to when the child turns two. It includes face-to-face home visits by a registered nurse trained in the Nurse Family Partnership fidelity model.

¹⁴ Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

¹⁵ Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

¹⁶ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,4,8,and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

¹⁷ As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

¹⁸ As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area¹¹</i>
3.	Childhood Obesity	Percent children w/ BMI >= 95th percentile of the sex-specific CDC BMI-for-age growth charts	Expand “Morning Mile” Program in certain high-risk communities ¹⁹	Expand “Morning Mile ²⁰ ” Program through investment of an agreed-upon amount by set date	Number of children participating in Morning Mile in high-risk communities	Hawkins, Sullivan, Greene ²¹	Russell, Scott, Grayson, Washington, Wise ²²
4.	Third Grade Reading Ability	Percent 3 rd graders reading at grade level	Expand “BEAR Buddies” program ²³	Expand “BEAR Buddies ²⁴ ” program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in Tennessee & Virginia in high-risk communities	Hancock, Cocke, Carter ²⁵	Bristol City, Buchanan, Wythe ²⁶
Key Focus Area #2: Help Adults Live Well in the Community							

¹⁹ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

²⁰ The Morning Mile is a before-school walking/running program that gives children the chance to start each day in an active way while enjoying fun, music and friends. The Morning Mile is currently sponsored in the Geographic Service Area by Mountain States. Additional Information is *available at*: <https://www.mountainstateshealth.com/medical-services/kohls-morning-mile>

²¹ As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Tennessee: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

²²As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Grayson, Washington, and Wise are in a three-way tie having the third highest obesity rate among the counties in the service region. Virginia: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

²³ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

²⁴ The BEAR (Being Engaged to Achieve Reading) Buddies program is a partnership between Niswonger Children’s Hospital and local schools designed to help children achieve early reading proficiency. BEAR Buddies pairs high school mentors with students in first, second or third grade who are six months or more behind in their reading level.

²⁵ Tennessee: TCAP District Level Results – 3rd through 8th Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.

²⁶ Virginia: SOL Assessment – 3rd Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area¹¹</i>
1.	Premature death from Cardiovascular Disease	Age-Adjusted Death Rates for Diseases of the Heart per 100,000	Expansion of community-based smoking cessation programs in certain high-risk communities ²⁷	Expansion of community-based smoking cessation programs through investment of an agreed-upon amount by set date	Number of participants in smoking cessation programs in high-risk communities	Unicoi, Cocke, Hancock ²⁸	Tazewell, Smyth, Scott ²⁹
2.	Premature death from Diabetes	Age Adjusted Death Rates for Diabetes Mellitus per 100,000	Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications ³⁰	Establish Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications by set date	Number of Physicians participating in quality improvement project	Hamblen, Carter, Greene, Sullivan ³¹	Scott, Smyth, Tazewell
3.	Premature death from Breast, Cervical, Colon and Lung Cancer	Age Adjusted Death Rates for Select Cancers per 100,000	Establish Faith-based screening campaigns for selected cancers (e.g. mammograms, prostate cancer) in specific high-risk counties ³²	Establish agreed-upon number of Faith-based screening campaigns in certain counties by set date	Number of parishioner screenings in high-risk counties	Hawkins, Cocke, Johnson ³³	Bristol City, Smyth, Buchanan ³⁴
Key Focus Area #3: Promote a Drug-Free Community							

²⁷ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,7,8,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

²⁸ "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

²⁹ "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

³⁰ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,7,8,9,10, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

³¹ Tennessee: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>. Greene and Sullivan counties tie for having the third highest rate among counties in the service area. Virginia: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

³² This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,7,8,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

³³ Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.

³⁴ Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area¹¹</i>
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program ³⁵	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins ³⁶	Dickenson, Wise, Tazewell, Buchanan ³⁷
2.	Tobacco use in Teens	Percent of teens currently smoking	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco in certain high-risk counties ³⁸	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco through an agreed-upon investment by set date	Number of anti-smoking impressions in high-risk communities	Hancock, Carter, Greene ³⁹	Wise, Dickenson, Buchanan ⁴⁰
Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured							
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers ⁴¹	Establish agreed-upon number of Integrated Care Management Programs for Uninsured Community Super-Utilizers by set date	Number of Uninsured Community Super-Utilizers in Active Care Management	Hancock, Unicoi, Cocke ⁴²	Buchanan, Russell, Lee ⁴³

³⁵ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,8,10,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

³⁶ Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

³⁷ Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

³⁸ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 11,2,4,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

³⁹ As county-level data on teen smoking was not available, adult smoking rates were used as a proxy. Tennessee: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

⁴⁰ As county-level data on teen smoking was not available, adult smoking rates were used as a proxy measure. Virginia: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

⁴¹ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,6,7,8,9,10,11,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁴² As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Tennessee." County Health Rankings. Accessed February 3, 2016.

⁴³ As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Virginia." County Health Rankings. Accessed February 3, 2016.

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<i>Health Concern</i>	<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area¹¹</i>	
Key Focus Area #5: Access to Behavioral Health Services							
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties ⁴⁴	Establish an agreed-upon number of Crisis Receiving Centers in specific hospitals by set date	Number of individuals managed in Crisis Receiving Center.	Hancock, Cocke, Hamblen ⁴⁵	Wise, Dickenson, Tazewell ⁴⁶

Representative Example:

If the State and the New Health System agree that one of the Key Focus Areas in the Commitment to Community Health Annual Report should be Ensuring Strong Starts for Children, one health concern the Parties suggest targeting is low birth-weight babies. The baseline for tracking this health concern would be the Low Birth Weight Rate per 100,000 population for specific counties within the Geographic Service Area. One investment, intervention, or performance improvement that the New Health System could undertake to address this health concern would be to establish evidence-based Home Visitation Programs in certain high-risk counties. The Representative Index Measures would reflect the New Health System's commitment to the State to establish an agreed-upon number of evidence-based Home Visitation Programs in certain counties by agreed-upon dates. The Progress Measures that could be used by the State and the New Health System to measure progress in addressing this health concern would be the percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs.

⁴⁴ This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3, and 8. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

⁴⁵ As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Tennessee: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

⁴⁶ As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Virginia: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

Periodic Review of the Commitment to Community Health Annual Report

The Parties recognize that population health is dynamic and the health challenges of a region will change over time. The Annual Report established when the COPA is granted should be periodically reviewed and updated to reflect these changes. The Parties propose that the initial Annual Report and its associated plan be established with the issuance of the COPA. On the fifth anniversary of the COPA, the New Health System and the State will evaluate the Annual Report to determine what adjustments, if any, need to be made to plan elements or accountability mechanisms. Once the New Health System and the State have agreed upon these changes, the updated elements of the Annual Report will go into effect on the sixth anniversary of the COPA for a period of five years. The Parties propose that the periodic review of the Annual Report be performed on the same intervals for as long as the COPA remains in effect.

B. Enhanced Health Care Services Measures

Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding.

For the second category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. **Table 11.8** below indicates five areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.8 - Proposed Enhanced Health Care Services Measures

Index of Public Advantage and Community Health Improvement		
B. Enhanced Health Care Services Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities	Annual progress reports and One-time report to State attesting

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	throughout the region.	to the creation of new capacity for residential addiction recovery services when complete.
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients’ homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.

C. Expanding Access and Choice Measures

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both. By integrating the two systems, the Parties will help ensure that communities in the Geographic Service Area continue to have access to the care they need close to home and that care options are expanded rather than reduced.

For the third category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to sustain and expand access and choice. **Table 11.9** below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.9 - Proposed Expanding Access and Choice Measures

Index of Public Advantage and Community Health Improvement		
C. Expanding Access and Choice Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions	Annual report to State attesting to compliance for five years after formation of the New Health System.

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	open.	
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.

D. Improving Health Care Value: Managing Quality, Cost and Service Measures

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of health care cost growth for patients, employers and insurers.

As evidence of their commitment to manage quality, cost, and service, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 11.10** below indicates ten areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.10 - Proposed Improving Health Care Value: Managing Quality, Cost and Service Measures

Index of Public Advantage and Community Health Improvement		
D. Improving Health Care Value: Managing Quality, Cost and Service Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System	Annual report to State attesting to compliance.

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	<p>negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.</p>	
	<p><i>Commitment</i></p>	<p><i>Proposed Accountability Mechanism</i></p>
<p>3.</p>	<p>The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.</p>	<p>Annual report to State attesting to compliance.</p>
<p>4.</p>	<p>The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.</p>	<p>Annual report to State attesting to compliance.</p>
<p>5.</p>	<p>The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.</p>	<p>Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.</p>
<p>6.</p>	<p>The New Health System will participate meaningfully in a health information exchange open to community providers.</p>	<p>Annual report to State attesting to compliance once health information exchange is fully established.</p>
<p>7.</p>	<p>The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.</p>	<p>Annual report to State attesting to measurement of quality measures identified in Section 8(A)(iv) of the COPA Application.</p>
<p>8.</p>	<p>The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.</p>	<p>Annual report to State attesting to compliance.</p>

9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.		

E. Investment in Health Research/Education and Commitment to Workforce

A cornerstone of the proposed merger is the expansion of the health-related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Tennessee and Virginia. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, and expanded services and training can also contribute to the economic vitality of the area and the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities both with health and economic well-being.

In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by becoming one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. The workforce is the lifeblood of a health care organization and the competition for the labor force will remain intense, both locally and regionally.

As evidence of their commitments to invest in health research and education and to attract and retain a strong workforce, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to achieve these goals. The table below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) of **Table 11.11** below.

Table 11.11 - Proposed Investment in Health Education/Research and Commitment to Workforce Measures

Index of Public Advantage and Community Health Improvement		
E. Investment in Health Education/Research and Commitment to Workforce Measures		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to State attesting compliance.
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State

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		once complete.
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.
6.	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.

Using the Index

The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure Public Advantage. To calculate the Overall Achievement Score, the Parties propose that the State assign a "Satisfied" or "Not Satisfied" evaluation to each of the five categories of the Index and that the five categories be given equal weight in the scoring process. The score for each category will be the number of measures within that category successfully satisfied divided by the total number of measures within that category. The five category scores should be combined to determine the "Overall Achievement Score" for each year of active State supervision to ensure Public Advantage.

Representative Example:

For each of the five categories, the State would assign a "Satisfied" or "Not Satisfied" evaluation to the individual measures agreed upon by the New Health System and the State in the COPA as demonstrated in **Table 11.12** below. If the Parties agreed upon the following Index of Public Advantage and Community Health Improvement, the state would evaluate each individual accountability mechanism as follows:

Table 11.12 - Demonstration of Evaluation

	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
A. Commitment to Improve Community Health			
1.	The New Health System is committed to creating a new integrated delivery system designed to improve	Annual report to State attesting to progress towards compliance	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	community health through investment of not less than \$75 million over ten years in population health improvement.	until \$75 million is invested.	
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the COPA.	Annual report to State attesting to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.	Satisfied
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.	Satisfied
B. Enhanced Health Care Services Measures			
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.	Satisfied
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients’ homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.	Satisfied
C. Expanding Access and Choice			
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the	Annual report to State attesting to compliance for five years after formation of the New Health System.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.		
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.	Satisfied
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.	Satisfied
5.	Independent physicians will not be required to practice exclusively at the New Health System’s hospitals and other facilities.	Annual report to State attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.	Satisfied
D. Improving Health Care Value: Managing Quality, Cost and Service			
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.	Satisfied
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing	Annual report to State attesting to compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System’s control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.		
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to State attesting to compliance.	Satisfied
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to State attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.	Satisfied
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in Section 8(A)(iv) of the COPA Application.	Satisfied
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.	Annual report to State attesting to compliance.	Satisfied
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.	Satisfied
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.	Satisfied
E. Investment in Health Education/Research and Commitment to Workforce			
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training	Annual report to State attesting compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	slots, create new specialty fellowship training opportunities, and add faculty.		
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.	Satisfied
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.			

In this representative example, the Overall Achievement Score would be calculated as demonstrated in **Table 11.13** below:

Table 11.13 - Demonstration of Overall Achievement Scoring

Category	Measures Satisfied	Overall Achievement Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	6/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	30/30	100%

Continuing Public Advantage

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered clear and convincing evidence of the Public Advantage and the COPA shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered clear and convincing

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evidence of the Public Advantage depending upon the relative circumstances, and the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered evidence, when considering the relative circumstances, that the Public Advantage of the COPA is no longer evident and the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification.

Due to the new and untested nature of the Index of Public Advantage and Community Health Improvement and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether the evidence of the Public Advantage is clear and convincing. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Index of Public Advantage and Community Health Improvement. Further, the Commissioner shall have discretion to determine that the clear and convincing standard has been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

Representative Examples:

Example 1. If the New Health System was able to satisfy most of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.14**:

Table 11.14 - Sample Scoring for Example 1

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	5/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	9/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	28/30	93.3%

An Overall Achievement Score of 93.3% is considered clear and convincing evidence of the Public Advantage and the COPA would continue in effect.

Example 2. If the New Health System was not able to satisfy some of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.15**:

Table 11.15 - Sample Scoring of Example 2

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	

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D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
Overall Achievement Score	19/30	63.3%

An Overall Achievement Score of 63.3% may be considered clear and convincing evidence of the Public Advantage, depending upon the relative circumstances considered by the Commissioner. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information in deciding whether to exercise his or her discretion in seeking a modification to the Cooperative Agreement. After considering the Public Advantage and the explanations for why any Measure has not been satisfied, the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA.

Example 3. If the New Health System was not able to satisfy several Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.16**:

Table 11.16 - Sample Scoring of Example 3

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	2/5	
C. Expanding Access and Choice	3/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	5/10	
E. Investment in Health Research/Education and Commitment to Workforce	2/6	
Overall Achievement Score	14/30	46.7%

An Overall Achievement Score of 46.7% may be considered evidence, depending on the relative circumstances, that the Public Advantage of the COPA is no longer evident. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information. The Commissioner would allow a reasonable period of time for a remediation plan to be developed, presented, accepted and implemented for re-evaluation. After considering the Public Advantage, the explanations for why any Measure has not been satisfied, and performance under the remediation plan, the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification. In deciding whether to take action to terminate the COPA under the terms of the certification, the Commissioner would have the authority to consider important public benefits that contribute to the Public Advantage even if those public benefits are not explicitly addressed in the Index of Public Advantage and Community Health Improvement.

Index of Public Advantage and Community Health Improvement Conclusion

The Parties believe that this Index of Public Advantage and Community Health Improvement proposal outlines a process for the New Health System to align its resources and commitments with the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of

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health care in the region. At the same time, the Parties believe that including the Department, the local departments of health, the Community Health Work Groups, the Advisory Groups, and other community stakeholders in finalizing these proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Ultimately, the Parties hope that this process will result in the highest chance of success for improving population health across our region.

Exhibits and Attachments

Exhibit Number	Description
Exhibit 11.4	Financial Summary for Mountain States
Exhibit 11.4 - Attachment A	Mountain States Bonds Official Statement for 2011 bonds
Exhibit 11.4 - Attachment B	Mountain States Bonds Official Statement for 2012 bonds
Exhibit 11.4 - Attachment C	Mountain States Bonds Official Statement for 2013 bonds
Exhibit 11.4 - Attachment D	Mountain States Covenant Compliance Certificates for the Last Five Years
Exhibit 11.4 - Attachment E	Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14
Exhibit 11.4 - Attachment F	Mountain States Audited Financial Statements for 2009 to 2014
Exhibit 11.4 - Attachment G	Mountain States EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
Exhibit 11.4 - Attachment H	Mountain States - Rating Agencies
Exhibit 11.5	Financial Summary for Wellmont
Exhibit 11.5 - Attachment A	Wellmont 2011 Bonds Official Statement for 2011 bonds
Exhibit 11.5 - Attachment B	Wellmont Audits – External Audited Financial Statements for 2011 to 2014
Exhibit 11.5 - Attachment C	Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
Exhibit 11.5 - Attachment D	Wellmont External Auditor Management Letters for 2011 to 2014
Exhibit 11.5 - Attachment E	Rating Agencies – Fitch and Standard & Poor's Reports
Exhibit 11.6	Current Annual Budgets for Mountain States
Exhibit 11.7	Current Annual Budgets for Wellmont
Exhibit 11.8	Five Year Projected Budget for New Health System
Exhibit 11.9	Mountain States Insurance Contracts and Payer Agreements
Exhibit 11.10	Wellmont Insurance Contracts and Payer Agreements
Exhibit 11.11	Existing and Future Business Plans of Mountain States
Exhibit 11.12	Existing and Future Business Plans of Wellmont
Exhibit 11.13	Alignment Policy
Exhibit 11.14	Institute of Medicine Vital Signs Core Measures

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September 12, 2016

Via Email and Hand Delivery

Allison Thigpen Rajaratnam, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Response to Tennessee Department of Health Request for Additional Information (#1) dated
March 28, 2016

Dear Allison:

Enclosed please find the First Amendment to the Master Affiliation Agreement requested by your office on March 28, 2016 from Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont"). This First Amendment updates the officers of the new parent company (NewCo, Inc.) as well as the members of the Integration Council. It also incorporates certain information from the Certificate of Public Advantage Application into the Master Affiliation Agreement as requested.

Mountain States and Wellmont appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Thank you for your assistance.

Sincerely,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ, PC



Claire Cowart Haltom
Counsel for Wellmont Health System

Enclosure

cc: Jane Young, Esq.
Jeff Ockerman, Esq.
Janet Kleinfelter, Esq.

Vic Domen, Esq.
Gary Miller, Esq.
Tim Belisle, Esq.
Robert E. Cooper, Jr., Esq.
J. Richard Lodge, Esq.
Richard G. Cowart, Esq.

March 16, 2016

Allison Thigpen, MPH
Health System Improvement Coordinator
Division of Health Planning
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: Tennessee Department of Health's Request for an Addendum to the Application for a Certificate of Public Advantage

Dear Ms. Thigpen:

The following information is being provided in response to your letter dated February 29, 2016, relating to the Department of Health's request for an addendum to the application for issuance of a Certificate of Public Advantage ("COPA"). Specifically, we wish to address the Department's objectives and positions raised in your January 15, 2016, written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report" and identify where each objective/position is addressed in the COPA Application submitted on February 16, 2016. Each objective/position posed in your January 15th letter is set forth in its entirety in the attached Addendum together with the location in the Application where that objective/position is addressed. We have also provided an explanation about how the Application section responds to the Department's observations and positions where appropriate.

Additionally, we have included information about the recent announcement that Wellmont's Chief Financial Officer, Alice Pope, will be joining HonorHealth, addressed a technical correction in Section 6 of the Application and accompanying Exhibits, and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E.

We appreciate the opportunity to provide the Department with additional information that we hope will be helpful in reviewing the COPA Application. We would be happy to discuss any of this information or any questions that you, or your colleagues, may have.

Sincerely,

Mountain States Health Alliance
President &
Chief Executive Officer



Alan Levine

Wellmont Health System
President &
Chief Executive Officer



Bart Hove

Enclosure

CC: Valerie Nagoshiner
Malaka Watson
Jeff Ockerman

ADDENDUM #1 TO THE

APPLICATION

CERTIFICATE OF PUBLIC ADVANTAGE

STATE OF TENNESSEE

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: March 16, 2016

MARCH, 2016

Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (collectively referred to as the "Applicants") submitted an application (the "Application") to the Tennessee Department of Health on February 16, 2016 for issuance of a Certificate of Public Advantage ("COPA").

The Tennessee Department of Health (the "Department") has requested that the Applicants provide an addendum to the Application to address the Department's objectives and positions raised in the Department's January 15, 2016 letter, which was written in response to the "Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report."

Each objective/position posed in the Department's January 15th letter is set forth in its entirety below, together with the location in the Application where that objective/position is addressed. The Applicants have also provided an explanation about how that particular section (or sections) responds to the Department's observations and positions where appropriate (Section 1 below).

Additionally, the Applicants wish to formally notify the Department of Alice Pope's planned departure from Wellmont Health System (Section 2 below), addressed a technical correction in Section 6 of the Application and accompanying Exhibits (Section 3 below), and provided full copies of Exhibits 11.4 - Attachment D and 11.4 - Attachment E (Section 4 below).

SECTION 1: RESPONSE TO THE DEPARTMENT'S JANUARY 15, 2016 LETTER

Observation #1 - Geographic Service Area

The report does not include counties in Kentucky and North Carolina in the geographic service area while the Letter of Intent, submitted September 16, 2015, does include these counties.

Department Position:

Consistent with department rule, "[i]f the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the application, a description of how and why the proposed geographic area differs and why changes are proposed" is required.

The department notes the Kentucky and North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. Unless the application, when it is submitted, includes a reasonable justification to exclude the Kentucky and North Carolina counties, the department will consider these counties, which are contiguous to counties with facilities of the New Health System, to be included in the service area.

Applicants' Response:

As the Department is aware, "geographic service area" is not defined in either the Tennessee COPA statute²⁴ or regulations.²⁵ A healthcare geographic service area may be defined in different ways, including by patient origin data, location of services, geographic features, political boundaries, population, and/or health resources. Since the Tennessee COPA statute and regulations do not define "geographic service area," the Applicants looked to the regulatory language for guidance. Tennessee Rules section 1200-38-01-.02(2)(a)(7) states:

If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed; [*emphasis added*]

For purposes of completing the COPA Application, the Applicants have interpreted the "proposed geographic service area" to mean the geographic area where the Applicants propose to conduct business as the New Health System.

The Applicants have historically served *patients* from a twenty-nine county area, which includes counties in Tennessee, Virginia, Kentucky, and North Carolina. While the Applicants serve patients from twenty-nine counties in Tennessee, Virginia, North Carolina, and Kentucky, Wellmont and Mountain States only have facilities and locations in Tennessee and Virginia. All of the Wellmont and Mountain States physical facilities and provider locations are located in Tennessee or Virginia and are subject to state regulations only in these two states. To the extent the Applicants draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Applicants' facilities and provider locations in Tennessee and Virginia.

Section 5 of the Application provides a detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. While the Applicants recognize that "geographic service area" may be defined in different ways, the Applicants have defined the "proposed geographic service area" in the COPA Application as the twenty-one counties in Tennessee and Virginia where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Tennessee and Virginia counties in which the Applicants have locations and facilities and serve residents, and all locations and providers that will be under the control of the Applicants and subject to any regulation under the COPA or Cooperative Agreement. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured.

²⁴ Tennessee Code Section 68-11-1301 et seq.

²⁵ Tenn. Comp. R. & Regs 1200-38-01-.01 et seq.

Since Wellmont and Mountain States have only operated facilities in Tennessee and Virginia over the five years preceding the application, the proposed geographic service area for the COPA Application does not differ from the service areas where the Applicants have conducted business over the five years preceding the Application.

The Department correctly notes that the two Kentucky counties and six North Carolina counties are regularly included in business documents detailing the service area of Mountain States Health Alliance. As explained above, a healthcare "service area" may be defined in different ways. Both Wellmont and Mountain States have served *patients* from a twenty-nine county area that includes counties in Tennessee, Virginia, Kentucky, and North Carolina. However, Wellmont and Mountain States only have facilities in Tennessee and Virginia. As shown in the tables below, which is based on the same discharge data used in the Application and published by Tennessee and Virginia, patients from the six North Carolina counties identified in the 29-county area account for one half of one percent (0.5%) of the combined patient discharges. Patients from the two Kentucky counties identified in the 29-county area account for less than one half of one percent (0.4%) of the combined patient discharges. Ninety-eight percent (98%) of the combined patient discharges come from the proposed geographic service area - the 21 counties in Tennessee and Virginia.

Patient County	With MDC 19 and 20					
	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	59,594	35,810	95,404	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	58,441	35,075	93,516	98.1%	97.9%	98.0%
Extended Service Area - NC**	456	35	491	0.8%	0.1%	0.5%
Extended Service Area - KY***	129	267	396	0.2%	0.7%	0.4%
All Other Counties	568	433	1,001	1.0%	1.2%	1.0%

Patient County	Without MDC 19 and 20					
	MSHA	WHS	Combined	MSHA %	WHS %	Combined %
Total	53,822	34,514	88,336	100.0%	100.0%	100.0%
Proposed 21 County Geographic Service Area*	52,835	33,828	86,663	98.2%	98.0%	98.1%
Extended Service Area - NC**	443	34	477	0.8%	0.1%	0.5%
Extended Service Area - KY***	123	263	386	0.2%	0.8%	0.4%
All Other Counties	421	389	810	0.8%	1.1%	0.9%

Notes:

Excludes DRG 795

Excludes Takoma Regional Hospital

*Includes the 21 counties and 2 independent cities across Tennessee and Virginia

**Includes the following six North Carolina counties: Ashe, Avery, Madison, Mitchell, Watauga, and Yancey

***Includes the following two Kentucky Counties: Harlan and Letcher

For the reasons stated above, the Applicants believe it is appropriate to define the geographic service area for purposes of the COPA Application as the twenty-one counties in Tennessee and Virginia.

Observation #2 - Prevention Services for all Categories of Payers

The description in the report of prevention services for all categories of payers lacks detail. For example, substance abuse prevention is the only specific example provided.

Department Position:

It is the department's position that, for the application to be deemed complete, prevention services will need to be more specifically enumerated. Consistent with department rule, the Cooperative Agreement must detail the "[p]roposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements...."²⁶

Applicants' Response:

In Sections 11.i and 11.j of the Application, the Applicants outline their commitments to improving community health through investment of not less than \$75 million over ten years in science and evidence-based population health improvement. Specifically, on pages 86-88 of the Application, the Applicants address the use of cost savings to fund prevention services across all payer groups. The Applicants interpret "such as" in the regulations cited by the Department to indicate that the proposed use of cost savings may be used for these types of programs or other types of programs that are designed to achieve long-term population health improvements. The Applicants expect that low or no-cost services such as screening programs and disease management programs will be essential elements of the plan to achieve long-term population health improvements as outlined in the Application. Additionally, the Applicants believe that focusing these low or no-cost programs for specific populations will likely yield the greatest long-term population health improvements. For example, immunization programs for children are well-established and well-funded in the region. However, improvements could be made with respect to immunization programs for pneumonia, flu, and HPV by targeting specific populations to help achieve greater results. The Applicants intend to invest in population health improvement efforts that generate more focused and meaningful value-based spending in the region. The sections of the Application addressing this position are included below for reference:

²⁶ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix)(II).

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

RESPONSE: The New Health System is committed to improving community health through investment of not less than \$75 million over ten years in science and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For example, the Northeast region²⁷ ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with

²⁷ The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. See <https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf> accessed February 4, 2016.

health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least \$140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; develop community-based mental health resources such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Observation #3 - Equity

The explanation of how the New Health System will provide equitable health services with respect to maintaining quality and competition within the service area needs further explanation.²⁸ The department acknowledges the report includes a discussion of access to services in rural areas.

²⁸ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)12(iii).

Still, the document primarily focuses on contracts with health plans and does not discuss the impact of the proposed merger on other payers and their respective populations, including Medicaid and Medicare populations and people without insurance.

Department Position

Consistent with department rules, the application should include policies that specifically address Medicaid and Medicare populations and people without insurance.²⁹ Moreover, the population health improvement plan detailed in the application should cover all residents in the geographic service area.

Applicant's Response:

As noted in Section 11.g.iii.III of the COPA Application, Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid population are housed within Mountain States. As part of the COPA Application, the Applicants provided the State with the current Charity Care and related policies of both Wellmont and Mountain States in the following exhibits:

Exhibit 8.4 - Attachment A	Mountain States' Charity Care Policy
Exhibit 8.4 - Attachment B	Mountain States' Credit and Collection Policy - Patient Accounts
Exhibit 8.4 - Attachment C	Mountain States' Collection Agency Process - Fiscal Services
Exhibit 8.4 - Attachment D	Mountain States' Code of Ethics and Business Conduct
Exhibit 8.5 - Attachment A	Wellmont's Patient Bill of Rights
Exhibit 8.5 - Attachment B	Wellmont's Charity Care Policy and Related Policies
Exhibit 8.5 - Attachment C	Wellmont Bad Debt, Bankruptcy, Small Balance Write-Off and Return Mail Policy

As explained on pages 73-76 of the Application, the New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. If the COPA is granted, the Applicants intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Applicants and consistent with the IRS's final 501(r) rules. The New Health System is a shell entity at this point with no authority to implement charity care or other policies that would govern the operations of the merged enterprise. However, as evidence of the Applicant's commitment to implement similar policies if the COPA is granted, the Applicants have committed in the executed

²⁹ Tennessee Department of Health Rule 1200-38-01-.02(2Xa)13(vii)(III)III[A-D].

Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Applicants.³⁰

To further address the Department's interest in the New Health System's provision of equitable health services, the Applicants address each category of patients on pages 74-76 of the Application. This section is included below for reference:

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured

³⁰ See COPA Application **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance, Section 1.02 "Community Benefit."

population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.
- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

Observation #4 - Health of the Region and Population Health Disparities

The identification and discussion of population health disparities is limited. While the report briefly highlights differences in health behaviors and outcomes among geographic entities, the report does not discuss other groups that often experience health disparities, e.g., racial/ethnic minority, rural and urban, age and gender disparities. The department also notes the report does not address physical activity, one of the Tennessee State Health Plan "Big Three +1" health issues (physical inactivity, obesity, tobacco use and substance abuse). As you know, evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health.

Department Position

For an application to be deemed complete, granular detail is needed regarding factors that influence the health and health disparities of counties, communities, and groups within them, particularly as it relates to the applicants' current assessment of existing trends and long-term population health outcomes.

The department also notes that, should a COPA be issued, the New Health System will be responsible for population health in the region for an indefinite period of time. The department is interested in additional longitudinal plans and New Health System expectations for regional population health improvement after the initially-proposed ten year period.

Applicants' Response:

In Section 8.A of the Application, the Applicants address the significant health care challenges that face the population of the geographic service area. As outlined on page 30, a 2015 Tennessee Department of Health report, *Drive Your County to the Top Ten*,³¹ found that:

- All Tennessee counties in the Geographic Service Area exceed the national average for smoking
- The state level obesity rate exceeds the national average, and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%).
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birthweight births and
- Three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates.

³¹ "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: <https://www.tn.gov/health/topic/specialreports>

Table 8.1 on page 31 of the Application reports key statistics on the population in the counties within the Geographic Service Area, including metrics for obesity, smoking, childhood poverty, and death rates due to drug poisoning. Full County Health Rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached to the Application as Exhibit 8.1A and 8.1B. Table 8.1 is provided below for reference.

Table 8.1 from the COPA Application

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	43rd	19%	32%	23%	27%	16
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015.
Accessible at www.countyhealthrankings.org

The Applicants specifically addressed the health priorities of the State in the discussion of the "Big Three Plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) on pages 31-35. As noted in the Application, these four health issues are particularly significant challenges for the Geographic Service Area and are associated with other health challenges and conditions that are responsible for higher health care utilization.

The Applicants' discussion of the "Big Three Plus One" issues from the Application are included below for reference:

Physical Inactivity & Obesity

Obesity and physical inactivity are mutually reinforcing public health concerns. Tennessee's state level obesity rate exceeds the national average. While most of the Tennessee counties in the 21-county geographic service area have obesity rates lower than the state average, Hawkins and Sullivan Counties are exceptions at 35% and 33% respectively. All of the Tennessee counties in the geographic service area exceed the state average for physical inactivity (30%). Most notably, Unicoi County has a physical inactivity rate of 37.0% and Hancock County has a physical inactivity rate of 39.4%. Measures for Virginia counties in the service area reflect challenges as well.

Tobacco Abuse

The "2015 Drive Your County to the Top Ten" report³² published by the Tennessee Department of Health Division of Policy, Planning, and Assessment State Department of Health demonstrates that all of the Tennessee counties in the 21-county geographic service area exceed the national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking. In particular, Hancock County and Carter County are at the high end of the range with smoking rates that exceed 30%.

Substance Abuse

Substance abuse is a key priority of the Tennessee Department of Health and a significant concern in this region. Of the ten Tennessee counties in the geographic service area, nine exceed the state average in the number of deaths due to drug poisoning per 100,000 population. Of particular note is Hancock County, which has the highest drug poisoning mortality rate in the state. Addressing substance abuse is one of the highest priorities of the New Health System, with efforts to address the specific needs of this population as well as improve access to, and coordination of care at, healthcare facilities for substance abuse patients.

³² "2015 Drive Your County to the Top Ten", Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015. Available here: <https://www.tn.gov/health/topic/specialreports>

Table 8.2 reports key statistics on the population in the counties in the 21-county area for the "Big Three +1" health issues, including metrics for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the County scores worse than the state average for that particular metric.

	Physical Inactivity Score ³³	Obesity ³⁴	Tobacco Abuse ³⁵	Substance Abuse Score ³⁶
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%		29%	22
Hamblen County	33%	30%	23%	27
Hancock County	39%	30%	40%	42
Hawkins County	35%	35%	26%	26
Johnson County	34%	31%	28%	11
Sullivan County	35%	33%	26%	17
Unicoi County	37%	30%	23%	24
Washington County	30%	31%	24%	17
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

* Red shading indicates that a County's score exceeds the state average.

³³ Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁴ Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁵ Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

³⁶ Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, available at <http://www.countyhealthrankings.org/>

The Parties share the State's concern about these four significant health issues and are aware of the acute challenges present in this region. The Parties intend for these four issues to be key areas of focus within the scope of the current Community Input Work Groups, as well as included in the Advisory Groups that will work to define the health index for the geographic service area.

The Applicants acknowledge that the New Health System will be responsible for population health in the region for an indefinite period of time. As a result, the New Health System has proposed a plan for development of the Index of Public Advantage and Community Health Improvement that includes input from community stakeholders and the State as outlined in Section 11.j of the Application. Additionally, the Applicants have set forth a proposal for development of this Index in Table 11.7, which identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Applicants propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Applicants have identified specific Health Concerns that pose an important challenge and priority for health in this region that are aligned with health challenges and priorities identified by the states. The Applicants have also identified a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally. The Applicants have proposed a representative investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area. The relevant Accountability Mechanism the Applicants believe reflects the New Health System's performance related to the investment, intervention, or performance improvement is also identified for each Health Concern. The Applicants have proposed a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern, and finally, the Applicants have identified County level disparities for each Health Concern as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

The Applicants seek to engage the COPA Index Advisory Group and the State in the final determination of the measures to be included in the Health Index. The Applicants expect to be held accountable for the commitments outlined in the Application and believe it is the goal of all those involved that the population health of the Geographic Service Area will improve with the New Health System's commitment of substantial resources and improved coordination of new and existing health programs.

Observation #5 - Duplication of Services

As noted in the report, MSHA and WHS currently have "expensive duplications of costs" and plan to reduce duplications post-merger through delivery model integration and "job displacement."³⁷ Limited detail of these plans is provided.

The department also notes that most other hospital mergers (including the merger of St. Joseph's Hospital and Memorial Mission Hospital in 1995 supervised by the State of North Carolina through a COPA) result in the reduction of the number of full-time equivalent positions.

Department Position:

Pursuant to department rule, the application must include "economic metrics that detail anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement."³⁸

To ascertain how efficiencies in operating costs and shared services could potentially impact population health and health care, the department needs additional detail to evaluate the potential benefits and disadvantages of these plans to achieve these cost savings. Specifically, the department will require a good faith estimate of the number of full-time equivalent positions estimated to be eliminated each year, or if none, other plans to achieve stated efficiencies.

Applicants' Response

Section 11.i of the Application details the anticipated efficiencies in operating costs and shared services the Applicants expect to gain through the Cooperative Agreement. As noted on pages 81-82 of the Application, funding the population health, access to care, enhanced health services, and other commitments described in the Application would be impossible without the efficiencies and savings created by the merger. The New Health System, by aligning Wellmont and Mountain State's individual efforts in key service areas, will be able to drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Applicants commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies to address this question in the Application. As detailed on pages 82-84 of the Application, the economies

³⁷ Wellmont Health System and Mountain States Health Alliance. Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report. January 2016. p. 8-9.

³⁸ Tennessee Department of Health Rule 1200-38-01-.02(2)(a)13(ix).

analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are addressed in the Application on pages 82-83 and copied below for reference:

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include
 - Harmonization to a Common Clinical IT platform
 - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
 - Reductions in unnecessary duplication of Call Pay
 - Reductions in Locum Tenens and use of "Registry Staff"
 - Renegotiations of service, maintenance, and other contracts
 - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
 - Added economies and efficiencies gained from the larger size of the New Health System.

The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately \$70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions

within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from the merger in labor expenses totaling approximately \$25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. **Clinical Efficiencies.** The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most

effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

The Applicants wish to specifically address the Department's questions about workforce. As detailed on page 83, the Applicants are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Applicants do not anticipate any merger-related reductions in force that would trigger federal or state notification obligations. At this time, the Applicants believe that the workforce adjustments can primarily be handled through reassignment of duties and normal attrition.

Additionally, in Section 11.f, beginning on page 67 of the Application, the Applicants address the State's questions about the impact of the merger on the service area's health care industry workforce. The Applicants' expect to achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by patient volumes and varies across the market from time to time. The Applicants recognize that health care workers are in great demand in this particular region, and retaining and developing excellent health professionals in the region will be of utmost importance to the New Health System to ensure the highest clinical quality.

Observation #6 - Reinvestment of Cost Savings

The report does not state whether the estimated \$450 million re-investment of cost-savings is a conservative or optimistic projection. The report also does not allow the reader to discern the estimate of the intervals and amounts of savings and subsequent reinvestments planned over the proposed ten year period.

Department Position

To allow the department to evaluate this aspect of public benefit, the application should include a good faith estimate of the expected annual expenditures in each reinvestment category that will be realized each year.

Applicants' Response:

The Applicants addressed this objective in Section 11.i of the Application in the discussion of the anticipated efficiencies in operative costs and shared services the Applicants expect to gain through the Cooperative Agreement. Specifically, the Applicants would like to draw your attention to the following:

At the end of "Non-Labor Efficiencies" section on page 82, the Applicants state:

The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

At the end of the "Labor Efficiencies" section on pages 83-84, the Applicants state:

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the

community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

At the end of the "Clinical Efficiencies" section on page 84, the Applicants state:

The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

SECTION 2: DEPARTURE OF ALICE POPE, WELLMONT'S CHIEF FINANCIAL OFFICER

On March 8, 2016, Wellmont Health System announced that Alice Pope, the system's executive vice president and chief financial officer, will become the new chief financial officer for HonorHealth in Scottsdale, Arizona. Pope will continue serving in her Wellmont leadership position, which she has held for 3 ½ years, for the next 60 days and will assist in a smooth transition. She has worked for Wellmont for 16 years, steadily advancing to positions of increasing responsibility. The timing of Pope's announcement was, in part, to allow strategic decisions to be made for Wellmont and for the new health system that would result from the proposed merger of Wellmont and Mountain States Health Alliance if the Application is approved.

In the term sheet and applications for a Certificate of Public Advantage in Tennessee and cooperative agreement in Virginia, Pope was designated to serve as the proposed new health

system's chief financial officer. The chief financial officer position for the proposed new health system will be evaluated by both Applicants given Pope's departure and the Applicants will notify the Department of any decisions by the Applicants that may affect the executive leadership structure of the New Health System or the COPA Application. The change is not expected to impact the proposed merger itself.

SECTION 3: TECHNICAL CORRECTION TO SECTION 6 OF THE COPA APPLICATION AND ACCOMPANYING EXHIBITS

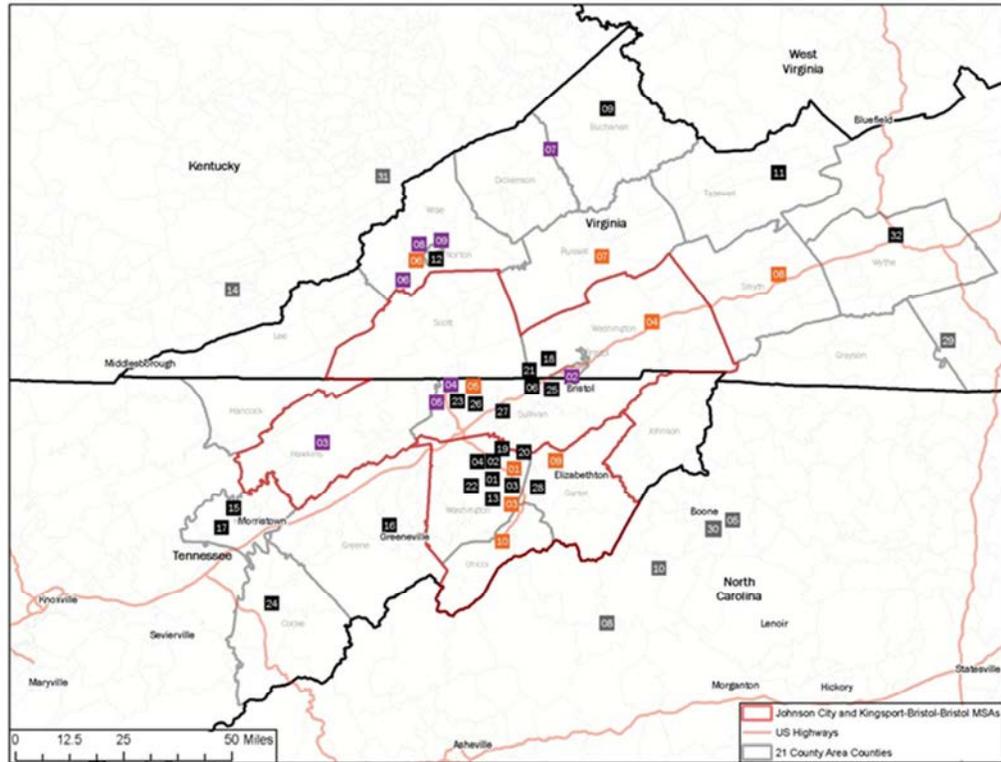
Section 6 of the Application and Exhibit 6.1D list the Ambulatory Surgical Center Locations and Counts, by System. Among the Ambulatory Surgical Center Locations listed in the Application is the State of Franklin OB/GYN, which is listed as performing surgery in an ASC setting. It has come to the Applicants' attention that the State of Franklin OB/GYN performs in-office surgical procedures but does not have an Ambulatory Surgical Center. To correct this oversight, the Applicants wish to remove the State of Franklin OB/GYN from the list of ASCs. This change will affect the following four sections of the Application:

1) Application Section 6 - pages 25-26

- Delete the following:

Wellmont and Mountain States each have ambulatory surgery centers ("ASCs")²⁴ in the area, but fifty-seven percent (57%) are competing facilities. The locations of all area ASCs are shown in Figure 6.3 below. Exhibit 6.1D lists all ASCs serving the Geographic Service Area.²⁵

Figure 6.3 – Map of Location of Ambulatory Surgical Centers²⁶



²⁴ ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

²⁵ The outpatient facilities listed in Exhibit 6.1D include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

²⁶ An enlarged version of the map and the legend are attached as Exhibit 6.1D.

- Replace it with:

Wellmont and Mountain States each offer outpatient surgery services²⁴ in the area, but fifty-five percent (55%) of the outpatient surgical facilities in the area are operated by competitors of Wellmont and Mountain States. The locations of all area outpatient surgical facilities are shown in **Figure 6.3** below. **Table 11.5** and **Exhibit 6.1A** break out the count and share for each category of outpatient surgical facilities while **Exhibit 6.1D** lists all outpatient surgical facilities serving the Geographic Service Area.²⁵

Figure 6.3 – Map of Location of Outpatient Surgical Facilities²⁶

2) Application Table 11.5

- Delete the following:

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS	Mountain	Mountain	Non-Managed		Total	
	Combined %	States	States- NsCH Affiliate	Wellmont	Joint Venture		All Other
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	50.0%	2	0	3	4	9	18
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

- Replace it with:

TABLE 11.5 - SHARES OF OUTPATIENT FACILITIES BY SYSTEM

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States- NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

3) Application Exhibit 6.1 - Attachment A

- Delete the following:

A. All Outpatient Facilities

Service Type	WHS & MSHS	Mountain	Mountain	Non-	Non-		Total
	Combined	States	States- NsCH	Managed	Joint	All Other	
	%		Affiliate	Wellmont	Venture		
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	50.0%	2	0	3	4	9	18
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

- Replace it with:

A. All Outpatient Facilities

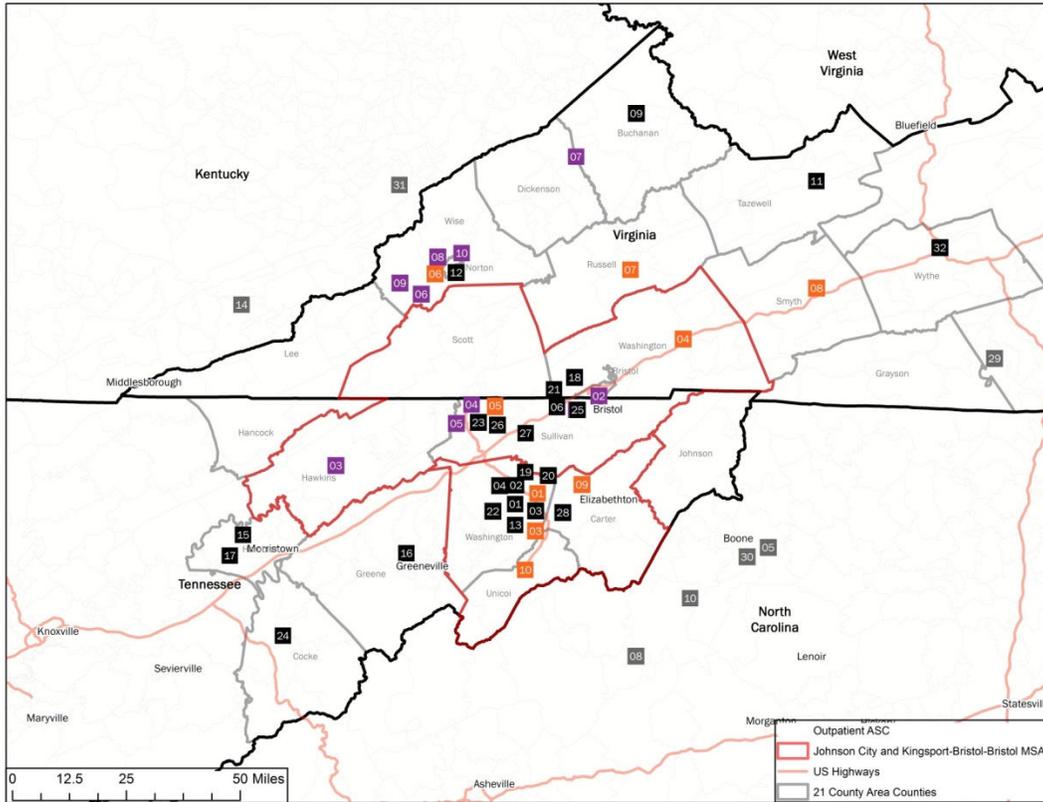
Service Type	WHS & MSHS	Mountain	Mountain	Non-	Non-		Total
	Combined %	States	States- NsCH Affiliate	Wellmont	Managed Joint	All Other*	
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

*All Other may include competing facilities located outside of the Geographic Service Area yet serving patients from the Geographic Service Area.

4) Application Exhibit 6.1 - Attachment D

- Delete the following:

D. Ambulatory Surgical Centers



Ambulatory Surgical Centers Outpatient Facilities	
Wellmont	
01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Sugery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital (<i>Independent</i>)*
09	Wellmont Loesome Pine Hospital
10	Wellmont Mountain View Regional Medical
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
22	State of Frankin OB/GYN Specialists
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital
MSHA	
01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital
All Other Facilities	
01	East Tennessee Ambulatory Surgery Center, LLC**
02	Johnson City Eye Surgery Center**
03	Mountain Empire Surgery Center, LP**
04	TriCities Laser Center**
05	Appalachian Gastroenterology

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Non-Managed Joint Venture

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
Total	Total			17	31	30
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA			X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Lonesome Pine Hospital	Wise	VA		X	
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	Total			3	5	5
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	Total			2	9	9
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

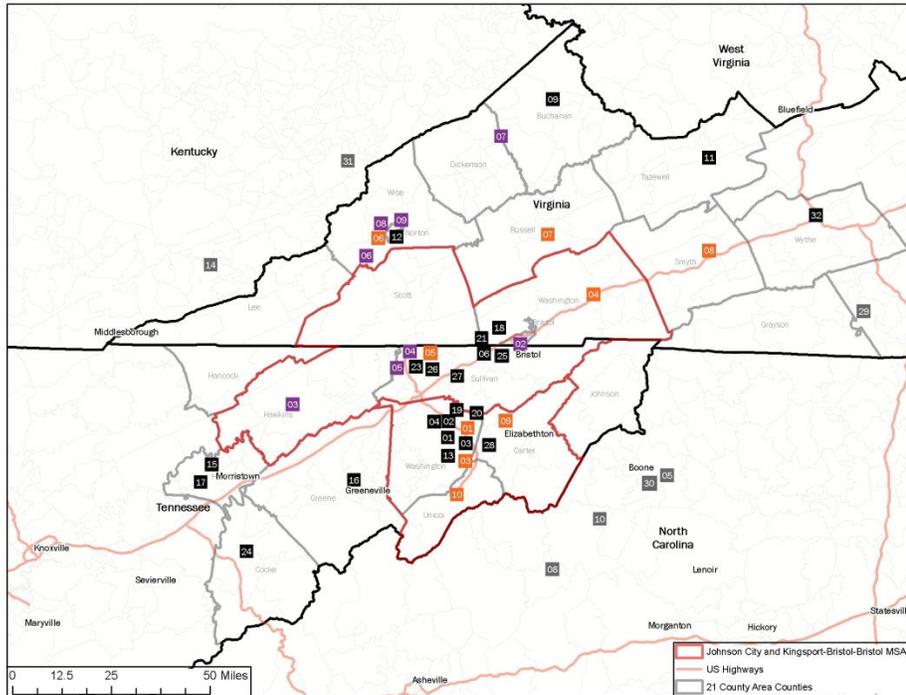
System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	Total			4	0	0
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Regional Surgical Services	Tazewell	VA	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	State of Franklin OB/GYN Specialists	Washington	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		

Ambulatory Surgical Center Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital- based
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	Total			8	17	16

- Replace it with:

D. Outpatient Surgical Facilities*



* Outpatient Surgical Facilities include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities. These facilities are included in the map and table.

Outpatient Surgical Facilities	
Wellmont	
01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital (<i>Independent</i>)*
09	Wellmont Mountain View Regional Medical
MSHA	
01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center**
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital
All Other Facilities	
01	East Tennessee Ambulatory Surgery Center, LLC***
02	Johnson City Eye Surgery Center***
03	Mountain Empire Surgery Center, LP***
04	TriCities Laser Center***
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital (“Takoma”) to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Managed Joint Venture

*** Non-Managed Joint Venture

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	Total			15	31	30
Wellmont	Bristol Regional Medical Center	Sullivan	TN		X	X
Wellmont	Bristol Surgery Center	Sullivan	TN	X		
Wellmont	Hawkins County Memorial Hospital	Hawkins	TN		X	X
Wellmont	Holston Valley Medical Center	Sullivan	TN		X	X
Wellmont	Holston Valley Surgery Center, LLC	Sullivan	TN	X		
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Sapling Grove ASC	Sullivan	TN	X		
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	Total			3	5	5
Mountain States	Franklin Woods Community Hospital	Washington	TN		X	X
Mountain States	Indian Path Medical Center	Sullivan	TN		X	X
Mountain States	Johnson City Medical Center	Washington	TN		X	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Kingsport Ambulatory Surgery Center**	Sullivan	TN	X		
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	Sycamore Shoals Hospital	Carter	TN		X	X
Mountain States	Unicoi County Community Hospital	Unicoi	TN		X	X
Mountain States	Total			2	9	9
Non-Managed Joint Venture	East Tennessee Ambulatory Surgery Center, LLC	Washington	TN	X		
Non-Managed Joint Venture	Johnson City Eye Surgery Center	Washington	TN	X		
Non-Managed Joint Venture	Mountain Empire Surgery Center, LP	Washington	TN	X		

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Non-Managed Joint Venture	TriCities Laser Center	Washington	TN	X		
Non-Managed Joint Venture	Total			4	0	0
All Other	Appalachian Gastroenterology	Watauga	NC		X	
All Other	Ashe Memorial Hospital	Ashe	NC		X	X
All Other	Blue Ridge Regional Hospital	Mitchell	NC		X	X
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Cannon Memorial Hospital	Avery	NC		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Endoscopy Center of Northeast Tennessee, PC	Washington	TN		X	
All Other	Harlan ARH Hospital	Harlan	KY		X	X
All Other	Lakeway Regional Hospital	Hamblen	TN		X	X
All Other	Laughlin Memorial Hospital	Greene	TN		X	X
All Other	Morristown-Hamblen Healthcare System	Hamblen	TN		X	X
All Other	Mountain Empire Cataract and Eye Surgery Center	Sullivan	TN	X		
All Other	PMA Surgery Center, LLC	Washington	TN	X		
All Other	Reeves Eye Surgery Center	Washington	TN	X		
All Other	Renaissance Surgery Center	Sullivan	TN	X		
All Other	Sullivan Digestive Center	Sullivan	TN		X	
All Other	Takoma Regional Hospital	Greene	TN			X
All Other	Tennova Healthcare - Newport Medical Center	Cocke	TN		X	X
All Other	The Endoscopy Center of Bristol	Sullivan	TN		X	
All Other	The Regional Eye Surgery Center	Sullivan	TN	X		
All Other	Tri Cities Gastroenterology	Sullivan	TN		X	

Outpatient Surgical Facility Types, Locations and Counts, by System

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
All Other	Tri-Cities Outpatient Surgery, LLC	Washington	TN	X		
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Watauga Medical Center	Watauga	NC		X	X
All Other	Whitesburg ARH Hospital	Letcher	KY		X	X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	Total			6	17	16

** Kingsport Ambulatory Surgery Center is a Managed Joint Venture.

SECTION 4: EXHIBITS 11.4 - ATTACHMENT D AND 11.4 - ATTACHMENT E

Certain exhibits were withheld from the Application because they contained competitively sensitive or confidential information of the Applicants. Among the exhibits withheld were Exhibit 11.4 - Attachment D - Mountain States Covenant Compliance Certificates for the Last Five Years and Exhibit 11.4 - Attachment E - Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14.

After further discussions with counsel, Mountain States has determined that these two exhibits (11.4 - Attachment D and 11.4 - Attachment E) should be filed publicly with the Department. The Applicants have attached these exhibits to this Addendum #1 for review by the Department.

The Applicants support the Department's commitment to transparency in reviewing the Application and will continue to work with counsel, the Department, and the Tennessee Attorney General's office to make all information required for the Application available to the Department while respecting federal antitrust laws.

Markets	Northwest	
Hospital	Lonesome Pine Hospital	Mountain View Regional Medical Center
System	Wellmont	Wellmont
Inpatient Services	X	X
Bariatrics		
Cardiac Surgery		
Cardiology	X	X
Cardiology Intervention		
Endocrinology	X	X
ENT Surgery	X	X
Gastroenterology	X	X
General Medicine	X	X
General Surgery	X	X
Gynecology	X	X
Hematology	X	X
Intensive Care	X	X
CICU		
SICU		
Neonatology	X	
Level 1	X	
Level 2		
Level 3		
Nephrology	X	X
Neurology		
Neurosurgery		
OB Deliveries	X	
Oncology Medicine	X	X
Oncology Surgery	X	X
Ophthalmology		
Oral Surgery		
Orthopedic	X	
Pediatric Unit		
Perinatology		
Plastic Surgery		
Psychiatry/Behavioral Health		
Pulmonary	X	X
Rehabilitation		
Thoracic Surgery		
Trauma		
Level 1		
Level 2		
Urology	X	X
Vascular Surgery		
Diagnostic Imaging	X	X

MRI	X	X
CT	X	X
PET	X	X
Emergency	X	X
Stroke Center		
Chest Pain Center		

Exhibit 15

NOTE: Volume reflects 25 or more discharges.

System	MSHA	MSHA	MSHA	MSHA	MSHA	Wellmont										
Hospital	Dickenson Community Hospital	Johnston Memorial Hospital	Norton Community Hospital	Russell County Medical Center	Smyth County Community Hospital	LPH/MVRMC										
Diagnostic Imaging	X	X	X	X	X	X										
Emergency	X	X	X	X	X	X										
Inpatient Services	X	X	X	X	X	X										
Cardiac Surgery																
Cardiology		627	242	119	167	270										
Cardiology Intervention		150														
Endocrinology		223	65	67	68	84										
ENT Surgery																
Gastroenterology		817	138	102	104	189										
General Medicine		1,237	280	156	230	327										
General Surgery		379	90		37	102										
Gynecology		52														
Hematology		88				29										
Neonatology		165	47			61										
Nephrology		485	144	94	99	132										
Neurology		300	126	29	43	47										
Neurosurgery																
OB Deliveries Sections		162	54			125										
OB Deliveries Vaginal		378	83			162										
OB Other		33	26			32										
Oncology Medicine		58														
Oncology Surgery																
Ophthalmic Medicine																
Ophthalmic Surgery																
Oral Surgery																
Orthopedic Medicine		87														
Orthopedic Surgery		323	32		77	34										
Otolaryngology		29														
Plastic Surgery																
Psychiatry				478												
Pulmonary		939	425	312	275	422										
Rehabilitation			47		164	89										
Rheumatology																
Substance Abuse		34														
Thoracic Surgery																
Trauma Medical																
Urology Medicine		31	25													
Urology Surgery		30														
Vascular Surgery		60														

VA, TN, NC State IP Data Through CY 2015

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume		Product Line							
Tennessee Hospital Name	System	Cardiac Surgery	Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology	General Medicine	
Carter, TN	Sycamore Shoals Hospital	MSHA	281	6	153		341	404	
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	249	41	96		321	228	
	Takoma Regional Hospital	All Other	156	1	47		195	286	
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	278	89	108		357	394	
Hancock, TN	Wellmont Hancock County Hospital	Wellmont	21		7		11	28	
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont	114		20		56	146	
Johnson, TN	Johnson County Community Hospital	MSHA	1				1	3	
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other							
	Indian Path Medical Center	MSHA	1	464	217	136	423	722	
	Wellmont Bristol Regional Medical Center	Wellmont	231	844	257	270	11	974	
	Wellmont Holston Valley Medical Center	Wellmont	263	1,196	683	328	19	982	
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA		51		16		79	
Washington, TN	Franklin Woods Community Hospital	MSHA		240	4	137	9	479	
	HealthSouth Quillen Rehabilitation Hospital	MSHA							
	Johnson City Medical Center	MSHA	273	2,050	1,203	479	14	1,489	
	Woodridge Psychiatric Hospital	MSHA		1				1	
Grand Total			768	5,946	2,501	1,797	53	5,709	
Lakeway data from 2014									
Hospital Name	Cardiac Surgery		Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology	General Medicine	
Tennova Healthcare-Lakeway Regional Hospital			184	3	62		247	123	
Grand Total			184	3	62		247	123	
Virginia Hospital County		Product Line							
Hospital Name	System	Cardiology	Cardiology Intervention	Endocrinology	ENT Surgery	Gastroenterology	General Medicine		
Buchanan, VA	Buchanan General Hospital	All Other	88		29		58	71	
Dickenson, VA	Dickenson Community Hospital	MSHA	1				1	2	
Russell, VA	Russell County Medical Center	MSHA	119		67		102	156	
Smyth, VA	Smyth County Community Hospital	MSHA	167		68		104	230	
Tazewell, VA	Carilion Tazewell Community Hospital	All Other	68		16		34	71	
	Clinch Valley Medical Center	All Other	377	66	151	1	390	267	
Washington, VA	Johnston Memorial Hospital	MSHA	627	150	223	4	817	1,237	
	Wellmont BRMC Ridgeview Pavilion	Wellmont						1	
Wise, VA	Norton Community Hospital	MSHA	242		117		259	567	
	Wellmont LPH/MVRMC	Wellmont	219		65	3	138	280	
Wythe, VA	Wythe County Community Hospital	All Other	135		20		96	196	
Grand Total			2,043	216	756	8	1,999	3,078	

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients residing within the 21 county service area only.

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume										
		General								OB Deliveries
Tennessee Hospital Name	System	Surgery	Gynecology	Hematology	Neonatology	Nephrology	Neurology	Neurosurgery	Sections	
Carter, TN	Sycamore Shoals Hospital	MSHA	151	13	46		272	112	1	
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	182	6	32	67	126	62	2	42
	Takoma Regional Hospital	All Other	115	14	25	78	53	68	1	53
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	135	25	32	161	201	190	5	136
Hancock, TN	Wellmont Hancock County Hospital	Wellmont		1	1		21	5		
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont	18		13		59	28		
Johnson, TN	Johnson County Community Hospital	MSHA					3			
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other	2					2		
	Indian Path Medical Center	MSHA	293	26	40	194	234	174	81	216
	Wellmont Bristol Regional Medical Center	Wellmont	677	56	112	214	504	622	339	222
	Wellmont Holston Valley Medical Center	Wellmont	851	141	165	207	544	610	284	268
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA	19	1	9		49	23		
Washington, TN	Franklin Woods Community Hospital	MSHA	356	30	34	338	260	82	2	326
	HealthSouth Quillen Rehabilitation Hospital	MSHA						1		
	Johnson City Medical Center	MSHA	1,173	123	242	755	842	1,138	529	330
	Woodridge Psychiatric Hospital	MSHA		1				28		
Grand Total			3,972	437	751	2,014	3,168	3,145	1,244	1,593
Lakeway data from 2014										
		General								OB Deliveries
Hospital Name	Cardiac Surgery	Surgery	Gynecology	Hematology	Neonatology	Nephrology	Neurology	Neurosurgery	Sections	
Tennova Healthcare-Lakeway Regional Hospital		68	15	34	19	153	75	40	25	
Grand Total		68	15	34	19	153	75	40	25	
		General								OB Deliveries
Virginia Hospital Name	System	Surgery	Gynecology	Hematology	Neonatology	Nephrology	Neurology	Neurosurgery	Sections	
Buchanan, VA	Buchanan General Hospital	All Other	16		5	1	68	3		
Dickenson, VA	Dickenson Community Hospital	MSHA					2			
Russell, VA	Russell County Medical Center	MSHA	2	1	10		94	29		
Smyth, VA	Smyth County Community Hospital	MSHA	37	18	22		99	43		
Tazewell, VA	Carilion Tazewell Community Hospital	All Other			2		46	11		
	Clinch Valley Medical Center	All Other	143	60	50	45	188	104	3	82
Washington, VA	Johnston Memorial Hospital	MSHA	379	52	88	165	485	300	5	162
	Wellmont BRMC Ridgeview Pavilion	Wellmont						1		
Wise, VA	Norton Community Hospital	MSHA	139	16	30	47	144	126	54	
	Wellmont LPH/MVRMC	Wellmont	90	20	17	48	109	36	105	
Wythe, VA	Wythe County Community Hospital	All Other	50	39	11	57	55	46	87	
Grand Total			856	206	235	363	1,290	699	8	490
Source: Discharge counts from THA and VHHA state databases. Includes discharges from pa										

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume										
		OB Deliveries		Oncology	Oncology	Ophthalmic	Ophthalmic			Orthopedic
Tennessee Hospital County	Hospital Name	System	Vaginal	OB Other	Medicine	Surgery	Medicine	Surgery	Oral Surgery	Medicine
Carter, TN	Sycamore Shoals Hospital	MSHA		2	30	8	3		2	28
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	94	6	27	4	2	2	2	27
	Takoma Regional Hospital	All Other	138	5	7	3	1			13
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	394	20	23	15			2	21
Hancock, TN	Wellmont Hancock County Hospital	Wellmont			1					4
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont			2				1	8
Johnson, TN	Johnson County Community Hospital	MSHA								
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other								1
	Indian Path Medical Center	MSHA	358	21	27	9	1		2	25
	Wellmont Bristol Regional Medical Center	Wellmont	427	45	114	49	3	1	12	152
	Wellmont Holston Valley Medical Center	Wellmont	462	45	130	73			15	161
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA		1	6	2				16
Washington, TN	Franklin Woods Community Hospital	MSHA	562	21	39	46	4		11	35
	HealthSouth Quillen Rehabilitation Hospital	MSHA			1					
	Johnson City Medical Center	MSHA	740	179	331	59	24	3	30	403
	Woodridge Psychiatric Hospital	MSHA								
Grand Total			3,175	345	738	268	38	6	77	894
Lakeway data from 2014										
		OB Deliveries		Oncology	Oncology	Ophthalmic	Ophthalmic			Orthopedic
Hospital Name	Cardiac Surgery		Vaginal	OB Other	Medicine	Surgery	Medicine	Surgery	Oral Surgery	Medicine
Tennova Healthcare-Lakeway Regional Hospital			53	1	24	7	2			22
Grand Total			53	1	24	7	2			22
Virginia Hospital County										
		OB Deliveries		Oncology	Oncology	Ophthalmic	Ophthalmic			Orthopedic
Virginia Hospital County	Hospital Name	System	Vaginal	OB Other	Medicine	Surgery	Medicine	Surgery	Oral Surgery	Medicine
Buchanan, VA	Buchanan General Hospital	All Other			2	1				5
Dickenson, VA	Dickenson Community Hospital	MSHA								
Russell, VA	Russell County Medical Center	MSHA			5				1	10
Smyth, VA	Smyth County Community Hospital	MSHA		3	11	10			2	17
Tazewell, VA	Carilion Tazewell Community Hospital	All Other								4
	Clinch Valley Medical Center	All Other	146	18	78	10	2		6	58
Washington, VA	Johnston Memorial Hospital	MSHA	378	33	58	17	5	1	9	87
	Wellmont BRMC Ridgeview Pavilion	Wellmont		2						1
Wise, VA	Norton Community Hospital	MSHA	83	26	11	14	1		1	16
	Wellmont LPH/MVRMC	Wellmont	128	28	10	2	1		1	6
Wythe, VA	Wythe County Community Hospital	All Other	98	10	6	3	1		1	10
Grand Total			833	120	181	57	10	1	21	214
Source: Discharge counts from THA and VHHA state databases. Includes discharges from pa										

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume									
			Orthopedic		Plastic				
Tennessee Hospital Name	System	Surgery	Otolaryngology	Surgery	Psychiatry	Pulmonary	Rehabilitation	Rheumatology	
Carter, TN	Sycamore Shoals Hospital	MSHA	97	10	9	154	663		8
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	142	23	4	4	561		5
	Takoma Regional Hospital	All Other	68	6		140	238	68	1
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	244	6	6	112	631		8
Hancock, TN	Wellmont Hancock County Hospital	Wellmont		1			57	4	2
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont		4	2	2	185	26	1
Johnson, TN	Johnson County Community Hospital	MSHA					9		1
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other						587	
	Indian Path Medical Center	MSHA	337	12	4	7	549		16
	Wellmont Bristol Regional Medical Center	Wellmont	740	26	25	820	1,291	1	25
	Wellmont Holston Valley Medical Center	Wellmont	1,145	31	26	19	1,534		45
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA	5	1	1		114		
Washington, TN	Franklin Woods Community Hospital	MSHA	1	46	1	3	572		16
	HealthSouth Quillen Rehabilitation Hospital	MSHA						420	
	Johnson City Medical Center	MSHA	1,364	94	18	92	2,086	1	118
	Woodridge Psychiatric Hospital	MSHA				3,385			
Grand Total			4,143	260	96	4,738	8,490	1,107	246
Lakeway data from 2014									
			Orthopedic		Plastic				
Hospital Name	Cardiac Surgery		Surgery	Otolaryngology	Surgery		Pulmonary		Rheumatology
Tennova Healthcare-Lakeway Regional Hospital			125	7	4		368		7
Grand Total			125	7	4		368		7
Virginia Hospital County									
			Orthopedic		Plastic				
Hospital Name	System	Surgery	Otolaryngology	Surgery	Psychiatry	Pulmonary	Rehabilitation	Rheumatology	
Buchanan, VA	Buchanan General Hospital	All Other		15	2		345		2
Dickenson, VA	Dickenson Community Hospital	MSHA				6			
Russell, VA	Russell County Medical Center	MSHA		7		478	312	2	2
Smyth, VA	Smyth County Community Hospital	MSHA	77	1		8	275	164	2
Tazewell, VA	Carilion Tazewell Community Hospital	All Other		1		1	122		2
	Clinch Valley Medical Center	All Other	67	16	6	11	679		8
Washington, VA	Johnston Memorial Hospital	MSHA	323	29	22	16	939		19
	Wellmont BRMC Ridgeview Pavilion	Wellmont				599			
Wise, VA	Norton Community Hospital	MSHA	32	16	5	6	425	47	8
	Wellmont LPH/MVRMC	Wellmont	25	10	4	1	348	89	4
Wythe, VA	Wythe County Community Hospital	All Other	113	6	6	3	190	85	4
Grand Total			637	101	45	1,129	3,635	387	51
Source: Discharge counts from THA and VHHA state databases. Includes discharges from pa									

Exhibit 13

From Share Database - CY 2015 Q1-3 Volume										
Tennessee Hospital Name		System	Substance Abuse	Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery	Vascular Surgery	
Carter, TN	Sycamore Shoals Hospital	MSHA	13	1	4		4	1		
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	3	1	6	1	8	8	43	
	Takoma Regional Hospital	All Other	7	2	7				15	
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	17	5	8		17	26	18	
Hancock, TN	Wellmont Hancock County Hospital	Wellmont			1		1			
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont	1	1						
Johnson, TN	Johnson County Community Hospital	MSHA								
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other								
	Indian Path Medical Center	MSHA	11	28	7		5	34	11	
	Wellmont Bristol Regional Medical Center	Wellmont	43	57	42	50	45	84	131	
	Wellmont Holston Valley Medical Center	Wellmont	26	106	48	20	29	70	257	
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA	3	1	1	1	2			
Washington, TN	Franklin Woods Community Hospital	MSHA	26	3	3		104	170	1	
	HealthSouth Quillen Rehabilitation Hospital	MSHA								
	Johnson City Medical Center	MSHA	139	156	122		50	92	456	
	Woodridge Psychiatric Hospital	MSHA	106							
Grand Total			395	361	249	72	265	485	932	
Lakeway data from 2014										
Hospital Name		Cardiac Surgery		Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery	Vascular Surgery	
	Tennova Healthcare-Lakeway Regional Hospital				7		9	27	6	
Grand Total					7		9	27	6	
Virginia Hospital County		Hospital Name	System	Substance Abuse	Thoracic Surgery	Trauma Medical	Unspecified	Urology Medicine	Urology Surgery	Vascular Surgery
Buchanan, VA	Buchanan General Hospital	All Other	2		1					
Dickenson, VA	Dickenson Community Hospital	MSHA								
Russell, VA	Russell County Medical Center	MSHA	5		2		4			
Smyth, VA	Smyth County Community Hospital	MSHA	4		1		3	2		
Tazewell, VA	Carilion Tazewell Community Hospital	All Other	3		1		2			
	Clinch Valley Medical Center	All Other	10	10	8		11	21	18	
Washington, VA	Johnston Memorial Hospital	MSHA	34	22	14	1	31	30	60	
	Wellmont BRMC Ridgeview Pavilion	Wellmont	16							
Wise, VA	Norton Community Hospital	MSHA	16	1	6		25	20	2	
	Wellmont LPH/MVRMC	Wellmont	5	1	1	2	2	1	3	
Wythe, VA	Wythe County Community Hospital	All Other	5	1	5		1		1	
Grand Total			100	35	39	3	79	74	84	
Source: Discharge counts from THA and VHHA state databases. Includes discharges from pa										

From Share Database - CY 2015 Q1-3 Volume			
Tennessee Hospital County	Hospital Name	System	Womens Other
Carter, TN	Sycamore Shoals Hospital	MSHA	5
Greene, TN	Laughlin Memorial Hospital, Inc.	All Other	
	Takoma Regional Hospital	All Other	
Hamblen, TN	Morristown-Hamblen Healthcare System	All Other	
Hancock, TN	Wellmont Hancock County Hospital	Wellmont	
Hawkins, TN	Wellmont Hawkins County Memorial Hospital	Wellmont	
Johnson, TN	Johnson County Community Hospital	MSHA	
Sullivan, TN	HealthSouth Rehabilitation Hospital-Kingsport	All Other	
	Indian Path Medical Center	MSHA	2
	Wellmont Bristol Regional Medical Center	Wellmont	1
	Wellmont Holston Valley Medical Center	Wellmont	3
Unicoi, TN	Unicoi County Memorial Hospital, Inc.	MSHA	
Washington, TN	Franklin Woods Community Hospital	MSHA	8
	HealthSouth Quillen Rehabilitation Hospital	MSHA	
	Johnson City Medical Center	MSHA	6
	Woodridge Psychiatric Hospital	MSHA	
Grand Total			25
Lakeway data from 2014			
Hospital Name	Cardiac Surgery		Womens Other
Tennova Healthcare-Lakeway Regional Hospital			1
Grand Total			1
Virginia Hospital County	Hospital Name	System	Womens Other
Buchanan, VA	Buchanan General Hospital	All Other	
Dickenson, VA	Dickenson Community Hospital	MSHA	
Russell, VA	Russell County Medical Center	MSHA	1
Smyth, VA	Smyth County Community Hospital	MSHA	
Tazewell, VA	Carilion Tazewell Community Hospital	All Other	
	Clinch Valley Medical Center	All Other	
Washington, VA	Johnston Memorial Hospital	MSHA	3
	Wellmont BRMC Ridgeview Pavilion	Wellmont	
Wise, VA	Norton Community Hospital	MSHA	1
	Wellmont LPH/MVRMC	Wellmont	1
Wythe, VA	Wythe County Community Hospital	All Other	
Grand Total			6
Source: Discharge counts from THA and VHHA state databases. Includes discharges from pa			

RESPONSE #10
TO QUESTIONS
SUBMITTED DECEMBER 22, 2016
BY
VIRGINIA DEPARTMENT OF HEALTH
IN CONNECTION WITH
APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: February 9, 2017

V.F.5.

5. What existing groups, organizations, or associations will NHS work with or finance toward achieving the stated goals and commitments?

JOINT RESPONSE: To address the social and economic factors that affect health, population health improvement initiatives must reach beyond the boundaries of the traditional health care system.¹⁵ The New Health System intends to use community-based partnerships that bring a wide range of stakeholders — clinical partners, public sector partners, private sector partners and payers — together to promote healthy behavior, improve access to primary and preventive care, and reduce health disparities. This approach has shown to be an effective means of improving population health.¹⁶

The New Health System will not be building these partnerships from scratch. Wellmont and Mountain States have long-standing relationships with stakeholders in each of these categories that have been cultivated over decades of community work. Because of these long-standing relationships, the community is primed for an Accountable Care Community model under the leadership of the New Health System. Below is a summary of the existing relationships with each of the categories of stakeholders, the regional penetration of that existing partnership, and a description of the New Health System's plans to build upon that relationship to successfully implement an Accountable Care Community.

Clinical Partners

(i) Hospitals

Current Status: Mountain States and Wellmont are the two primary health systems operating in the Geographic Service Area. Their tertiary and ambulatory networks work hand in hand with smaller area hospitals, including those operated by the two health systems, as well as a variety of home health, rehab, and other post-acute providers and thousands of independent physicians. As comprehensive health systems, Wellmont and Mountain States include a full spectrum of care options for patients in a traditional fee-for-service, hospital-centric care delivery model. Both health systems have experience managing ventures into population medicine or risk-based models including Accountable Care Organizations and Patient Centered Medical Homes (PCMH) practices. Each system also manages a substantial number of value-based-purchasing, pay-for-performance, or bundled payment models - including those with insurance companies,

¹⁵ According to a widely cited model from the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, population health is determined by several different factors—with access to and the quality of clinical care accounting for just 20 percent.

¹⁶ See THE COMMONWEALTH FUND, *Improving Population Health Through Communitywide Partnerships* (Feb./Mar. 2012) ("Community health partnerships that bring clinicians together with civic groups, social service providers, and educational leaders among many others are proving to be an effective means of improving population health.").

state Medicaid programs, and CMS. The health systems currently support community health improvement activities in partnership with other organizations, such as Healthy Kingsport, and support the social needs of community members through their own foundations' patient assistance funds. Under their social responsibility requirements both systems also provide significant donations to a number of community organizations that provide education and relief across the region, and employees of the two health systems actively volunteer in the community.

In addition to the hospitals owned by Wellmont and Mountain States, independent hospitals and hospitals associated with other health systems operate in Tazewell, Grundy, Wytheville, and Richlands, Virginia and in Morristown, Newport, and Greeneville, Tennessee.¹⁷

The systems also have relationships with hospitals outside the region for the purposes of facilitating local patient access to highly specialized services not available in the region. These include St. Jude's Hospital in Memphis for oncology care, Shriners Hospital in Greenville, South Carolina for orthopedics, Vanderbilt Hospital in Nashville for sub-specialty services.

Regional Penetration: Hospitals are located in nearly every county within the Geographic Service Area, with tertiary hospitals centered in the Tri-Cities and community hospitals located in more rural markets.¹⁸

New Health System Strategy: The New Health System will create a cohesive regional approach to population medicine, which allows the current fee-for-service and hospital-centric model to further develop into a community health improvement organization. The new model will proactively seek to prevent disease, in addition to treating it effectively, and will center its existence on the Triple Aim. The New Health System will expand internal mechanisms needed to assume more risk for the health status of the populations it serves and will work with partners to establish an Accountable Care Community organization capable of high-performing collaboration to enact community health improvement. In addition to sustaining the current investments in community benefit, the New Health System will invest \$450 million over ten years to empower its new focus, both internally and externally, in support of the population health plan and will work with partners to implement and actively supervise that investment.

(ii) Physician Groups and Other Providers

Current Status: Thousands of physicians operate in the Geographic Service Area, the vast majority of which are independent from the two health systems.¹⁹ Large physician

¹⁷ General acute care hospitals in the Geographic Service Area not operated by Wellmont or Mountain States include: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, and Newport Medical Center. See Application Exhibit 5.2.

¹⁸ See Application Exhibit 5.1.

groups in the area include Holston Medical Group, Clinch Valley Physicians Inc., and Mountain Region Family Medicine.

Through its Integrated Health Solutions Network subsidiary, MSHA operates the AnewCare Collaborative ACO, which manages approximately 14,000 MSSP lives in Virginia and Tennessee. Of these 14,000 lives, more than 60% (approximately 8,700) reside in Southwest Virginia. About 4,000 of the AnewCare MSSP lives are seen by independent physicians. AnewCare also manages approximately 17,000 TennCare lives under contract with Amerigroup. AnewCare is one of the few MSSP programs that have received shared savings during each year of its existence and received high quality scores in excess of 2015.

While Wellmont Medical Associates and Mountain States Medical Group are owned and operated by the two health systems, both health systems work with all of the physicians on the medical staffs, as well as community-based physicians and post-acute care providers, to care for mutual patients. Both Wellmont and Mountain States manage provider networks. Mountain States' Integrated Health Solutions Network maintains a provider network in Virginia and Tennessee, which consists of both Mountain States providers and independent physicians and facilities. Within Virginia, there are 45 facilities, 310 allied health professionals, and more than 350 physicians within the Mountain States network (ISHN). This network is made available to a variety of insurers, including BlueCross BlueShield of Tennessee and the Virginia Medicaid MCOs: InTotal Health, Optima Sentara, Coventry/Aetna, and Virginia Premier. Wellmont similarly participates in Highlands Wellmont Health Network, a physician-hospital organization which provides a network of providers and contracts with insurance companies as well as providing services for self-insured businesses.

Both Wellmont and Mountain States currently participate in the One Partner HIE as contributing providers, meaning they provide data to the HIE which helps all participating physicians manage care more effectively and efficiently. In addition, through its Epic EHR system, Wellmont offers Epic Carelink at no cost to regional physicians who need to access to health system based patient records from their offices or for their own care management efforts.

Most of the larger medical groups in the Geographic Service Area, have established patient-centered medical homes (PCMH) practices employing the national standards set forth by the American Medical Group Association and similar organizations to better coordinate the care management of patients. These PCMH initiatives manage chronic disease such as diabetes and contributors to the development of disease such as obesity and tobacco use. Both Mountain States and Wellmont operate NCQA Patient Centered Medical Home (PCMH) practices, which provide a baseline standard for a care team that is focused on better-coordinated management of patients. Wellmont does not currently operate a PCMH practice in Virginia, but Mountain States operates eleven PCMH practices in Virginia, each certified by the National Committee for Quality Assurance

¹⁹ Of the more than 2,000 physicians in the Geographic Services Area, approximately seventy percent (70%) are independent. See Application, Exhibit 14.1E.

(NCQA), and this certification was achieved over time as payers increasingly incentivized or required this, or similar, certification. (See Response P-2a for more information about the Parties' Virginia PCMHs) The NHS plans to pursue the Expanded Chronic Care Model (ECCM), described in more detail in the Applicants' Response K-7b/K-7d. NCQA PCMH certification increasingly has required more components of the ECCM with an emphasis on team-based care, focus on the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow-up with external support organizations. The extended primary care team utilizes RN care management, patient navigators, QI specialists and pharmacists.

The development of these initiatives, together with regional ACO strategies and their associated care management departments, have helped to create a new orientation to patient care especially in the major medical groups. This new orientation has contributed to area physician groups' ability to succeed in value-based payment models.

Federally Qualified Health Centers, Rural Health Centers, and Charity Clinics also house important physician resources, especially for primary care and dental services. These centers are especially important to bridging care gaps in rural areas and in reaching underserved and uninsured populations in both rural areas and cities. Federally Qualified Health Centers include Stone Mountain Health Services and Southwest Virginia Health Systems operating in Southwest Virginia and the Rural Health Consortium operating in Northeast Tennessee. Charity Clinics include the Health Wagon and Crossroads Medical Mission operating in Southwest Virginia and Friends in Need and Healing Hands operating in Kingsport, Tennessee and Bristol, Tennessee respectively. A variety of other faith-based or community clinics also contribute to serving the underserved and uninsured populations of the area.

Regional Penetration: Physician practices are concentrated in the more populated areas of the Geographic Service Area but span the area, and the majority of independent physicians operate in proximity to the more populated areas. Specialty physicians are also primarily based in population centers, with a few exceptions. Physician needs in the more rural areas are primarily supported by the two health systems, independent hospitals or Federally Qualified Health Centers, along with notable independent practices such as C-Health in Virginia and Medical Care LLC in Tennessee. Because of difficulty recruiting physicians to rural areas, Mountain States and Wellmont both employ larger percentages of physicians in these rural areas than they do in the more populated areas.

New Health System Strategy: The New Health System seeks to build on the work that has already begun in the regional ACOs to further align clinical efforts through a more cohesive clinical network that includes employed and independent physicians. This strategy will emphasize the mutually supportive contributions to common population health medicine strategies aimed at reducing cost, improving quality, and increasing access to prevention and best practice treatment resources. In furtherance of this strategy, the New Health System will collaborate in good faith with independent physician groups to develop a local, region-wide, clinical services network to share data,

best practices and efforts to improve outcomes for patients and to deliver such outcomes at the highest possible value.

As described in the “Overview” Section of the Ballad Health Alignment Overview,²⁰ physician group leaders will be important leaders for the Accountable Care Community and a cross-section of regional physicians will contribute to the Physician Clinical Council—where clinical protocols and strategies to derive efficiency and improve quality will be vested for the New Health System. Each of these organizations will be a cornerstone for community health improvement. As noted above, the NHS plans to pursue the Expanded Chronic Care Model (ECCM), described in more detail in the Applicants’ Response K-7b/K-7d. NCQA PCMH certification increasingly has required more components of the ECCM with an emphasis on team-based care, focus on the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow-up with external support organizations. The ECCM is more fully discussed in “The New Clinical System” document included in the Ballad Health Alignment Overview.

The Parties recognize that effective population health management requires continuous integration of clinical services across providers, care settings, and medical conditions. As such, the Ballad Health Alignment Overview contains a plan for the NHS to transition to a value-based approach to health care delivery that contemplates greater alignment of both incentives and operations under a single physician-led council and overall leadership may also include the development of a clinically integrated network in partnership with the independent physician community. This cohesive clinically integrated network would explore opportunities to span the continuum of care, including a high-performing primary care network that encompasses a sufficient network of community physicians, needed specialty physicians, ancillary services, home health, rehabilitation, pharmacy and other needed clinical resources to serve the needs of patients comprehensively and manage costs and outcomes across the continuum.

In addition, the sharing of health information will be essential to this network. The New Health System has committed to adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. The New Health System will make access to the IT Platform available on reasonable terms to all physicians in the service area. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, and post-acute care and outpatient services and facilitate the move to value-based contracting. The New Health System will also grant reasonable access to the data collected in its Common Clinical IT Platform to researchers with credible credentials for the purpose of conducting research in partnership with the New Health System. The New Health System will not only work to develop the Common Clinical IT Platform but will also meaningfully participate in a regionally accessible health information exchange. The New Health System will seek to empower independent group participation in cooperation with large regional medical groups.

²⁰ See [Exhibit T-32A](#).

(iii) Non-Acute Care Providers

Current Status: This clinical category includes rehabilitation centers, nursing homes, home health and hospice, and pharmacies - organizations which touch patients both before and after acute care experiences. Mountain States and Wellmont, as well as our physician networks, work closely with a variety of these non-acute care providers to manage the care of patients, but much of that work is disconnected and uncoordinated today. Some exceptions exist, for instance, where the two health systems have integrated programs such as home health and hospice, long-term care and rehab, or where post-acute care networks have been developed for more strategic management of patient care with agreed upon protocols and effective hand-offs. However, many of these relationships could benefit from a coordinated approach to care.

Regional Penetration: There are scores of such providers throughout the Geographic Service Area which share important roles in the non-acute care of patients.

New Health System Strategy: The New Health System will work to establish a shared information network with these non-acute care providers and to establish a best practice set of protocols for the management of patients. The protocols will solidify the New Health System's relationship with the providers that commit to a shared approach to best practices. Ballad will expand on Mountain States current preferred Skilled Nursing Facility network to include discharges from previous Wellmont hospitals. This approach has demonstrated outcomes for reducing readmissions and improving care outcomes across the continuum of care²¹ and will be mutually supportive for these providers, the New Health System, and managing physicians, especially where payers are aligning incentives, such as around the avoidance of re-admissions.

(iv) Behavioral Health and Substance Abuse Providers

Current Status: As of now, the Parties offer behavioral health services that are limited to treatment of patients within the Emergency Departments and within three dedicated inpatient units: 10 geropsych beds at Dickenson Community Hospital in Clintwood, 20 adult psychiatric beds at Russell County Medical Center in Lebanon, and 28 adult psychiatric beds at Wellmont Ridgeview in Bristol, Virginia. Additional inpatient facilities are operated by the Parties in Tennessee: MSHA's Woodridge Hospital in Johnson City, Tennessee, and WHS's inpatient facilities at Bristol Regional Medical Center and at Takoma Regional Hospital in Greeneville, Tennessee. Historically both health systems have been focused primarily on inpatient psychiatric services with minimal outpatient services. In addition to the Parties' limited services, the Virginia Department of Behavioral Health and Development Services operates a 179-bed state psychiatric institute in Marion known as the Southwestern Virginia Mental Health Institute. Outpatient services are provided by Highlands Community Services in Abingdon, VA and Frontier Health in Johnson City, TN, which provide the majority of outpatient services in the area, along with a host of independent practitioners. Both health systems have

²¹ See Melanie Evans, *Hospitals select preferred SNFs to improve post-acute outcomes*, MODERN HEALTHCARE (May 9, 2015), available at <http://www.modernhealthcare.com/article/20150509/magazine/305099987>.

relationships for the management of crisis patients and those in need of inpatient placement, most notable are the relationships with Frontier Health. Both Parties also work closely with the Cumberland Mountain, Highlands, Mount Rogers, PD1, and Dickenson County Community Service Boards and Frontier Health, which provide a range of outpatient and residential behavioral health services. These relationships are described more fully in Responses K-6 and L-11.

Regional Penetration: Overall, behavioral health resources in the Geographic Service Area are not sufficient or not sufficiently aligned to meet needs, especially in the rural areas. Most available behavioral health resources are concentrated in the more populated areas, and crisis stabilization for patients is difficult overall, but especially in the rural areas. There is little disagreement that the inpatient-focused model increases costs, creates significant gaps in care and is inadequate to meet the growing mental health needs of the population. Despite the rampant substance abuse issues in the area, there is currently no regionally cohesive strategy for best-practice outpatient or inpatient substance abuse treatment and rehabilitation.

New Health System Strategy: The New Health System plans to make a major investment in behavioral health and substance abuse resources in the Geographic Service Area. As outlined in the Application, the New Health System has committed \$140 million towards the expansion of needed services which includes \$85 million for mental health and addiction recovery.²² These approaches are described more fully in Responses K-6 and L-11.

Public Sector Partners

Public sector partners include public pre-school, primary, secondary, and higher education institutions, health authorities, public health, local and state governments, county commissions, local health councils, public health departments, community service boards, economic development agencies, housing and welfare agencies, courts, and law enforcement agencies.

Current Status: As with private sector partners, these organizations work in important ways to meet community needs which contribute to health outcomes and have existing partnerships with the two health systems, but currently, the overall efforts are disjointed and not centered on common goals and objectives.

Regional Penetration: Organizations operating in the public sector span the region and reach thousands of individuals and families through a variety of social and educational services.

New Health System Strategy: The New Health System will include public sector partners in (i) strategic focus of initiatives and compliance under the Cooperative Agreement, (ii) the development of the Community Health Improvement Plan, (iii) the Academics and Research Plan, and (iv) the formation, governance, and operation of the Accountable Care Community.

²² See Response L-1 for a more detailed description of this commitment.

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While the Commissioner will be the primary person responsible for regulation and active supervision of the Cooperative Agreement, The Parties have made revised Commitments in consultation with the Southwest Virginia Health Authority that contemplate a significant role for the Authority under the Cooperative Agreement. The New Health System's partnership with the Authority in connection with the Cooperative Agreement is described in detail in Response G-1, and the Authority's role will include the following:

- Joint Task Force. Together with the Authority, the New Health System will create a Joint Task Force comprised of four members, two from the New Health System and two from the Authority. The Task Force will meet at least annually to guide the collaboration between the Authority and the New Health System and to track the progress of the New Health System toward meeting the commitments of the cooperative agreement, and the Task Force will report such progress to the Authority. The Task Force will be chaired by a member of the Authority. The members appointed by the Authority may not have a conflict of interest. (Revised Commitment 33)
- Authority Input in New Health System's Annual Priorities for Quality Improvement. In order to enhance quality of patient care through greater transparency, improve utilization of hospital resources, and to ensure the population health of the region is consistent with goals established by the Authority, the New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers. Such reporting shall include posting of quality measures and actual performance on New Health System's website accessible to the public. The New Health System shall report such data timely so the public can easily evaluate the performance of the New Health System as compared to its competitors, and ensure consumers retain the option to seek services where the quality is demonstrably the highest. In addition, the New Health System will timely report and include on its web site its performance compared to the Medicare quality measures including readmission statistics. The New Health System will give notice to the Authority of the metrics the New Health System is prioritizing, and will, in good faith, include input from the Authority in establishing or modifying its priorities. (Revised Commitment 8)
- Alignment of GME and Research Plans with Authority Goals. The New Health System will develop and implement, in partnership with at least its current academic partners, (1) a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee, and (2) a 10-year plan for investment in research and growth in the research enterprise in Virginia and Tennessee service area. These plans will include how they will address the Authority's goals. (Revised Commitments 17 and 18)

In addition, public Schools will be especially important to the prevention efforts of the New Health System, and strong relationships already exist with many of these schools for the provision of tele-health services for clinics, exercise equipment and training, pre-diabetes assessment and education, and walking and reading programs. It will be critical for the New

Health System to work with the public sector to leverage new and existing spending and resources. Certain public sector partners will have significant involvement with the New Health System. The expertise and partnership of regional health departments will be essential to informing and guiding the work of the Accountable Care Community. Local public health offices can have a significant role in development of the needs assessment, performance measurement and improvement, health promotion, and patient engagement necessary for a successful Accountable Care Community. They may also be able to assist with the collection of population health data related to risk factors and disease incidence, and provide technical assistance in reporting quality performance measures. The NHS will work closely with its current academic partners in Virginia and Tennessee to develop a collaborative research and academics strategy and infrastructure. This is more fully described in Response C-9.

Private Sector Partners

Private sector partners include a variety of non-profit and academic institutions including United Way agencies, Chambers of Commerce, businesses, faith-based organizations, relief agencies, food pantries, family support agencies and the like, along with local private schools, colleges, and universities.

Current Status: Wellmont and Mountain States have important academic and community relationships with these organizations, including board membership, financial support, and key partnerships. Some of the more integral academic relationships include the provision of clinical educators or adjunct faculty members for private nursing programs or physician assistant programs, or fully integrated residency programs, as in the case of the existing partnerships with the Edward Via College of Osteopathic Medicine and the Debusk College of Osteopathic Medicine. In many cases, the health systems are founding or sustaining partners for community organizations dedicated to health improvement - such as Healthy Kingsport, a regional health improvement organization, or Project Access, which provides regional access to specialist physicians and case management services along with navigation services.

There are many significant community partnerships as well. United Way of Southwest Virginia is a key private sector partner Mountain States works with on a number of initiatives, including grade level reading, childhood obesity, and Backpacks Unite. Mountain States has played an important role in UWSWVA's Unite Southwest Virginia Initiative, a collaborative approach among all community partners: education, health care, industry, manufacturing, small business, government, faith based organizations and nonprofits to improve the health of the region by breaking the cycle of poverty and leading more families and individuals to financial independence. Another private sector partnership is Mountain States' support of Feeding America's mobile food pantry. While Mountain States, as part of this newly formed relationship, provides financial assistance to Feeding America's provision of healthy food options and its expansion into an additional location, the real benefit of this relationship goes beyond monetary support. Through this relationship Mountain States is able to identify the health services it will seek to provide to the vulnerable population receiving mobile food services, which include free flu shots, health screenings, health education and other services. Once such health services

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needs are assessed, Mountain States will identify ways to provide access to much needed health care services for a population that depends on others for food support.

Similarly, Wellmont has advanced a variety of health improvement efforts in partnership with regional United Way agencies and other partners. This includes the provision of resources, including clinical support for organizations that serve the poor and homeless. Long-term partnerships include Friends in Need, Healing Hands, and Crossroads Medical Mission. In addition, Wellmont has provided scholarships so that disadvantaged children can participate in after school programs at the local YMCAs—including health, fitness, and nutrition opportunities and reading and math tutoring programs. Through local funding and partnership efforts in the Big Stone Gap community, Wellmont has supported community parks and the ongoing programs of organizations such as Mountain Empire Older Citizens. Another major Wellmont initiative has been the support and education of local EMS agencies through the development of the Level One Heart Attack Network. This network includes the provision of 12-lead EKG equipment to local ambulance services—particularly those throughout Southwest Virginia—and the training needed for field application of EKGs with transmission to local hospitals for quicker diagnosis of heart attacks and mobilization of patients to appropriate and accessible heart catheterization labs for intervention.

One example of a strong partnership with both public and private partners is the Kohl's Morning Mile program. Niswonger Children's Hospital and Kohl's Department Store are currently partnering with 60 elementary and middle schools across the region to provide access to this program which promotes morning walking and running for children before school. Healthy Habits Kits are awarded each month to the Kohl's Morning Mile student who has achieved the greatest miles and days of participation. This program has been steadily growing over the past three years and plans to add five more schools. Currently nearly 40,000 children participate and so far, three have logged over 80,000 miles in this new school year alone. Community grants are available to schools with the highest student participation and these funds are earmarked for fitness equipment to augment the school's physical education program.

Another example is Wellmont's partnership with local schools through Project Fit America, which includes a sixteen year effort to enhance physical activity and education offerings, primarily at rural or underserved schools throughout the region. Sixteen elementary schools have received outdoor play/exercise equipment along with ongoing training and alternative indoor equipment working with physical education teachers and school administrators. Virginia schools include Weber City Elementary, Appalachia Elementary, Saltville Elementary, Duffield Primary School, Powell Valley Primary School, Yuma Elementary, Nickelsville Elementary, and Ervinton Elementary.

There are many other examples of relationships Wellmont and Mountain States have with private sector partners. This work is important, but today, much of it is disconnected and lacks cohesive regional strategy.

Regional Penetration: Organizations operating in the private sector span the region and reach thousands of individuals and families with a variety of social and educational services.

New Health System Strategy: The New Health System's strategies in the private sector are similar to its strategies in the public sector. The New Health System will focus on three strategic directions with private sector partners (i) the development of the Accountable Care Community and the Community Health Improvement Plan, (ii) the development of the Academics and Research Plan, and (iii) the development of integral relationships with businesses, schools, and faith-based organizations to implement prevention strategies. Through the formation of the Accountable Care Community, the New Health System will identify essential private sector partners and outline the key contributions each will commit to making in support regional systems for community health improvement. These partners will be engaged in the development and implementation of the Community Health Improvement Plan, and the New Health System will work to scale best efforts and increase capacity through the committed \$75 million investment with a focus on those which align most closely with community health improvement goals. The New Health System has also committed to working with existing academic partners to identify needs for clinical education and graduate medical education to increase the pipeline of nursing, allied health, and physician professionals serving in the area through an \$85 million investment in Academics and Research. Finally, the New Health System will work with regional businesses, faith-based organizations and schools to extend prevention education and resources in order to help reduce health risk in populations. These efforts will include the provision of onsite, tele-health, and embedded resources such as health coaches and health educators.

The Parties have already begun work to engage further its private sector partners. In the fall of 2015, the Parties launched the region's most substantial community health improvement assessment effort to date, bringing together partners from all sectors, including the private sector, to participate. Four Community Health Work Groups were created to specifically focus on medical needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. As described in the Application,²³ the Parties jointly sponsored and funded these Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement. As noted, the Work Groups included many private sector partners including the chairpersons of the groups, who are listed below. The charters and membership lists of all four Work Groups are set forth in Application Exhibits 15.2A and 15.2B, respectively.²⁴

- Mental Health & Addiction Work Group: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families Work Group: Travis Staton, CEO of United Way of Southwest Virginia, and Dr. David Wood, chair of the department of pediatrics at ETSU;

²³ Application Section 15.a.G, pages 89-91.

²⁴ The membership lists reflect all members of each Work Group as of January 25, 2016.

- Population Health & Healthy Communities Work Group: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics Work Group: Jake Schrum, president of Emory & Henry College, and Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of ETSU.

The initial reports of the Work Groups are attached as **Exhibit F-5** and are still being assessed by the Parties. The reports are not intended as a final planning document or list of priority focus areas for the NHS, but they do provide important, current information the Parties can use as they develop their ten-year Community Health Improvement Plan for their Southwest Virginia and Northeast Tennessee patients.

Payers

Payers and health care providers are complementary but distinct stakeholders. Payers can advance population health by creating a financial model that incentivizes physicians and delivery systems to focus on better health, affordability and patient experience. These relationships will be critical to the move from fee-for-service to value-based reimbursement. For further information related to value-based care and contracting, please see the Responses to questions E-5, G-8, K-1, O-9, and **Exhibit T-32A** (the Ballad Health Alignment Overview), the latter of which contains Ballad Health's comprehensive integration strategy that will enable it to transform from traditional fee-for-service to value-based population health.

Current Status: Wellmont and Mountain States work with government and private payers, including self-insured companies and insurance carriers, to serve those covered under their plans. Though the historic relationship has been between payer and payee, the relationship is evolving to a more integral level of partnership. As incentives to manage the care of patients evolve into savings in pay for performance models (including the PCMH models mentioned above), the New Health System will become more involved with employers in helping to manage the health risks of employees proactively through various business health departments.

Regional Penetration: A very high percentage of existing patients are Medicare and Medicaid patients or are patients covered by managed care plans for those agencies. The majority of commercial beneficiaries in the region participate in employer-based plans or through third-party administrator arrangements offered by Anthem, Humana, Cigna, United or BlueCross BlueShield of Tennessee. Wellmont and Mountain States participate in all of these plans and the vast majority of these plans include both health systems in their networks.

New Health System Strategy: The goal of the New Health System is to move from the traditional payer-payee relationship to a partner role where the goals of the health system and the payer are aligned. This will result in shared savings for both the payer and the New Health System through improved efficiency and quality of care. The New Health System will work with payers to align systems of prevention and education to reduce both the incidence and progression of disease and to keep those populations it serves well. The New Health System's aim is to create a fourfold relationship that includes the New Health System, its physician partners,

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patients/beneficiaries, and payers to develop a cohesive set of strategies around population health improvement. With a relatively small number of major payers and a regionally integrated delivery system, the New Health System has a phenomenal opportunity to align goals, incentives, and resources to support the singular goal of community health improvement in the Geographic Service Area. Payers, including insurance companies and businesses, will be invited to play an essential role in the development of the Community Health Improvement Plan and the Accountable Care Community.

INDEX OF DOCUMENTS:

- Exhibit F-5 Joint Community Health Work Groups Initial Reports

V.I.1.

I. Insurance Relationships

1. Please describe all existing insurance relationships by insurance company or carrier and by Virginia facility.

MSHA RESPONSE: The requested information is provided.

MSHA believes that Exhibit that **Exhibit I-1A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit I-1A MSHA Description of Insurance Program – **PROPRIETARY**

WHS RESPONSE: Wellmont Health System has multiple lines of insurance as set forth in Exhibit I-1B. All of the coverages with the exception denoted in Exhibit I-1B are secured under Wellmont Health System as the parent corporation, with coverage provided to Wellmont and its subsidiaries in both TN and VA.

WHS believes that Exhibit that **Exhibit I-1B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit I-1B WHS Description of VA Insurance Contracts – **PROPRIETARY**

V.N.8.

8. Please provide a copy of all requests or orders from the FTC, any other federal agencies and from Tennessee antitrust agencies.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibits N-8A and 8B** are proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-8A MSHA Governmental Requests – 1– PROPRIETARY
- Exhibit N-8B MSHA Governmental Requests – 2– PROPRIETARY

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibits N-8C and 8D** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-8C WHS Governmental Requests – 1– PROPRIETARY
- Exhibit N-8D WHS Governmental Requests – 2– PROPRIETARY

JOINT RESPONSE: The Tennessee Department of Health has submitted to the Parties requests for additional information. These requests are publicly available on the Tennessee Department's website and are attached as **Exhibit N-8E**.

INDEX OF DOCUMENTS:

- Exhibit N-8E Joint Governmental Requests

V.N.9.

9. Please provide complete copies of all submissions to the FTC or any other federal agency or to any Tennessee agency.

MSHA RESPONSE: Exhibit N-9A will be provided as soon as possible, and all other requested information is provided.

MSHA believes that **Exhibits N-9A and 9B** are proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-9A MSHA Responses to Governmental Requests – 1– **PROPRIETARY – To be provided**
- Exhibit N-9B MSHA Responses to Governmental Requests – 2– **PROPRIETARY**
- Exhibit N-9C MSHA Responses to Governmental Requests – 3

WHS RESPONSE: Exhibit N-9D will be provided as soon as possible, and all other requested information is provided.

WHS believes that **Exhibits N-9D and 9E** are proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit these Exhibits separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-9D WHS Responses to Governmental Requests – 1– **PROPRIETARY – To be provided**
- Exhibit N-9E WHS Responses to Governmental Requests – 2– **PROPRIETARY**
- Exhibit N-9F WHS Responses to Governmental Requests – 3

V.N.10.

10. Please provide copies of all strategic plans, management plans or operational plans developed for MSHA and WHS since 2009.

MSHA RESPONSE: The requested information is provided.

MSHA believes that **Exhibit N-10A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-10A MSHA List of Strategic Plans and MSHA Existing & Future Business Plans – **PROPRIETARY**
- Exhibit N-10B MSHA Strategic Plan Data – **PROPRIETARY**

WHS RESPONSE: The requested information is provided.

WHS believes that **Exhibit N-10C** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit N-10C WHS Strategic Plan Update – **PROPRIETARY**

V.O.1.

O. The Virginia Facilities

- 1. Provide a list of services for each Virginia facility. Indicate which of the services currently offered is a “necessary or needed service”, i.e. services that cannot be eliminated without undue disadvantages to Virginia patients. Provide a five (5) year forecast of additional services for each facility indicating necessary services.**

JOINT RESPONSE: In order to preserve hospital services in geographical proximity to the communities traditionally served by such facilities, to ensure access to care, and to improve the utilization of hospital resources and equipment, the NHS commits that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. The New Health System has committed to performing physician needs assessment in each community in the Geographic Service Area every three years and investing in the recruitment and retention of physicians in the area, preferably by assisting independent physician groups to identify and employ new physicians, but also by employing physicians where independent practices cannot or choose not to employ these needed physicians. The physician needs assessments will help identify health care gaps in each community and will influence specialty care service offerings. The first community needs assessment and physician/physician extender recruitment plan will be presented to the Commissioner no later than in the annual report submitted after the end of the first full fiscal year after closing of the merger. (See Revised Commitment 25, **Exhibit G-1A**)

After the initial five-year period, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the NHS, and continued investment in health care and preventive services based on the demonstrated need of the community. The NHS may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any hospital, it will continue to provide essential services in the community. For purposes of this commitment, the following services are considered “essential services”:

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;

- Primary care services;
- Access to behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth of the Authority.

If the New Health System becomes the primary health service partner of the Lee County Hospital Authority, the New Health System will be responsible for essential services as outlined above. (See Revised Commitment 20, **Exhibit G-1A**)

Neither organization currently produces 5-year plans at this level of detail given the difficulty of projecting quickly changing technology and service landscapes. In addition, to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that may not be shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. We regret that we are unable to provide the requested information for the five (5) year forecast period at this time due to these concerns.

WHS RESPONSE: **Exhibit O-1A** lists services for each of WHS's Virginia facilities. For the reasons set forth in the Joint Response above, on the Exhibit we have designated emergency room care, emergent obstetrical care services, outpatient diagnostic procedures, rotating general medical specialty care consultations, helicopter or high acuity transport to tertiary centers, and telemedicine specialty consultation from tertiary centers as "necessary or needed services."

INDEX OF DOCUMENTS:

- Exhibit O-1A WHS's Services at Virginia Hospitals

MSHA RESPONSE: The requested information is provided.

INDEX OF DOCUMENTS:

- Exhibit O-1B MSHA Services at Virginia Hospitals

V.O.10.

10. Please provide revenue and expense statistics for each NHS Virginia facility for the five (5) year historical baseline period, YTD and the five (5) year forecast period.

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that may not be shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. We regret that we are unable to provide the requested information for the five (5) year forecast period at this time due to these concerns.

MSHA RESPONSE: The requested historical and YTD information is provided in **Exhibit O-10A**. MSHA does not forecast revenue and expense statistics for individual facilities, however please see the FTI Report and the New Health System 5-year projected budget (Excel format) in **Exhibit M-3C** for forecast information.

MSHA believes that **Exhibit O-10A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit O-10A MSHA Revenue and Expense Statistics – **PROPRIETARY**

WHS RESPONSE: The requested historical and YTD information is provided in **Exhibit O-10B**. WHS does not forecast revenue and expense statistics for individual facilities, however please see the FTI Report and the New Health System 5-year projected budget (Excel format) in **Exhibit M-3C** for forecast information.

WHS believes that **Exhibit O-10B** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit O-10B WHS Revenue and Expense Statistics – **PROPRIETARY**

V.P.2.

2. Please list each Virginia facility that will adopt the concept of a “medical home”.

- a. Detail the medical staff model at each Virginia facility to support this concept, or any other concept that emphasizes primary care and continuity of care.**

JOINT RESPONSE: Most of the larger medical groups in the Geographic Service Area, have established patient-centered medical homes (PCMH) practices employing the national standards set forth by the American Medical Group Association and similar organizations to better coordinate the care management of patients. These PCMH initiatives manage chronic disease such as diabetes and contributors to the development of disease such as obesity and tobacco use. Both Mountain States and Wellmont operate NCQA Patient Centered Medical Home (PCMH) practices, which provide a baseline standard for a care team that is focused on better-coordinated management of patients. Wellmont does not currently operate a PCMH practice in Virginia, but Mountain States operates eleven PCMH practices in Virginia, which are listed in the Table below.

Table P-2 – MSHA PCMHs in Virginia

Specialty	County	Practice
Primary Care	Dickenson	MSMG Dickenson Medical Associates
Primary Care	Russell	MSMG Riverside Clinic
Primary Care	Washington, VA	Emory Internal Medicine
Primary Care	Washington, VA	MSMG Glade Spring Family Medicine
Primary Care	Washington, VA	MSMG Internal Medicine - Abingdon
Primary Care	Washington, VA	Primary Care Center of Abingdon
Primary Care	Wise	MSMG Community Physicians - Big Stone Gap
Primary Care	Wise	MSMG Community Physicians - Norton
Primary Care	Wise	MSMG Community Physicians Wise
Primary Care	Wise	MSMG Thomas E Renfro Community Clinic
Primary Care	Wythe	MSMG Family Medicine - Rural Retreat

Each of the MSHA PCMHs listed above is certified by the National Committee for Quality Assurance (NCQA), and this certification was achieved over time as payers increasingly incentivized or required this, or similar, certification. The NHS plans to pursue the Expanded Chronic Care Model (ECCM), described in more detail in the Applicants’ Responses K-7b and K-7d. NCQA PCMH certification increasingly has required more components of the ECCM with an emphasis on team-based care, focus on the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow-up with external support organizations. The extended primary care team utilizes RN care management, patient navigators, QI specialists and pharmacists.

A full description of the care model (the Expanded Chronic Care Model) that the NHS will pursue throughout its facilities, including Virginia, is included in Responses K-7b and K-7d. NCQA PCMH certification has, over time, required more components of the ECCM with an emphasis on team-based care, focusing the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow up with external support organizations. The extended primary care team increasingly utilizes RN care management, patient navigators, QI specialists and pharmacists.

- a. **Detail the quantitative benefits of the number of patients in “medical home arrangements” for the two (2) year historical baseline period, YTD and the five (5) year forecast period.**

JOINT RESPONSE: The Parties are unable provide the requested information for the New Health System for the five (5) year forecast period because it would require the Parties to share competitively sensitive information that may not be shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. We regret that we are unable to provide the requested information for the five (5) year forecast period at this time due to these concerns.

While we cannot provide quantitative benefits for the forecasted period, the qualitative benefits of Wellmont’s and Mountain States’ Patient Centered Medical Homes are detailed in Response K-7b/d.

MSHA RESPONSE: The following describes the quantitative benefits, in aggregate over the last 3 years, for patients in MSHA’s medical home arrangements:

Mountain States Medical Group has approximately 28,000 covered lives in medical home arrangements with our payer partners. We have built a quality team infrastructure of 26 team members to assist in managing this population. Our team consists of care coordinators, care managers, clinical pharmacists, report analyst, clinical leader, and a medical director of quality improvement.

Through MSMG’s focused efforts on closing gaps in care, we have seen an improvement in our percent of measures at a 4-STAR target or greater. An example with our MSSP population is the focused effort on improving vaccination rates for the pneumococcal vaccines. We were able to improve from the 50th percentile in 2014 to the 70th percentile in 2015.

With an additional focus placed on improved transitions of care, we saw an estimated 2% decline in our readmission rate in target populations.

In collaboration with our subsidiary’s ACO, AnewCare, we have been able to achieve shared savings for the past 3 years.

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Since the addition of our first clinical pharmacist in fall 2015 (second started in fall 2016) – there have been close to 1,000 interventions leading to improved patient safety, avoidance of adverse drug events and an estimated \$1M in healthcare claims savings. Interventions include reduction of duplicative therapies, elimination of medications with drug-drug interactions, moving patients to lower cost generic alternatives, etc.

MSHA's eleven Virginia PCMH practices are listed in Table P-2 above.

WHS RESPONSE: While Wellmont Medical Associates has focused on PCMH certification in Tennessee (due to insurance initiatives) we have shared and instituted all protocols and their benefits to every WMA practice - including those in Virginia. It is our hope other insurers (including those in Virginia) will see the value to PCMH and help to fund the initiative via grants or pay for performance which would assist the medical group defray some of the costs associated with implementation and certification by NCQA.

Our goal in the future remains to have all our Primary Care Practices PCMH certified.

Currently the patients served benefit from standardization of protocols for such disease states as asthma, hypertension and diabetes (both from PCMH and other ongoing initiatives).

V.P.3.

3. Please detail the number of patients by county that either MSHA or WHS have by managed care fee for service and other arrangements in conjunction with their employed physicians in the two (2) year historical baseline period and YTD for each Virginia facility. Provide a five (5) year forecast for each Virginia facility. List the number of physicians by specialty that will be recruited by the NHS to enhance the percent of population under care.

JOINT RESPONSE: In order to provide the requested information for the New Health System for the five (5) year forecast period, the Parties would be required to share competitively sensitive information that may not be shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. We regret that we are unable to provide the requested information for the five (5) year forecast period at this time due to these concerns.

MSHA RESPONSE: The requested historical and YTD information is provided in **Exhibit P-3A**. MSHA does not forecast revenue and expense statistics for individual facilities, however please see the FTI Report and the New Health System 5-year projected budget (Excel format) in **Exhibit M-3C** for forecast information.

MSHA believes that **Exhibit P-3A** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit P-3A MSHA Patients Managed by Employed Physicians – **PROPRIETARY**

WHS RESPONSE: The requested historical and YTD information is provided in **Exhibit P-3B**. WHS does not forecast revenue and expense statistics for individual facilities, however please see the FTI Report and the New Health System 5-year projected budget (Excel format) in **Exhibit M-3C** for forecast information.

WHS believes that **Exhibit P-3B** is proprietary, confidential and competitively sensitive under federal antitrust laws. MSHA will submit this Exhibit separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit P-3B WHS Patients Managed by Employed Physicians – **PROPRIETARY**

V.Q.14.

14. Provide the applicants' anticipated five (5) and ten (10) year timeline with milestones for development and implementation for the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. If none presently exist, will one be developed? At a minimum, the timeline should include targeted objectives for each year following the formation of the NHS, including target dates for the following activities:

- a. Behavioral health capability. If the chosen Clinical IT system does not currently include a behavioral health module, detail the applicants' plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors and any opportunities for facilitating the NHS' collaboration with Virginia's CSBs.
- b. Integration of systems and/or linkage of records (medical, lab, pharmacy, diagnostic, and referral/scheduling).
- c. Migration and/or archiving of pre-existing records.
- d. Training for new users (System and non-System providers).
- e. Patient access to information and protection of such information.
- f. Capabilities for collecting, analyzing, and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers(System and non-System).

JOINT RESPONSE: If the Cooperative Agreement is approved, the Parties will follow the IT Strategy outlined in Section 7 of the Ballad Health Alignment Overview, which has been provided with these responses as **Exhibit Q-2C**. The Overview outlines the process the Parties will follow to create its IT system. It includes details on the development of the Common Clinical IT Platform, the central component of the IT system, which will enable the New Health System to pursue population health and risk-based contracts.

The initial step for the development and implementation of the Common Clinical IT platform is to perform an IT assessment. The Parties estimate it will take at least six months to complete the assessment after the merger. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, the Parties have developed a high-level timeline for implementation of the Common Clinical IT Platform is submitted with these responses as Exhibit Q-2A, and it contains targeted objectives for each year following the formation of the NHS for each of the listed activities above. Additionally, Exhibit Q-2B contains information previously submitted to the Authority regarding the Common IT Platform, including plans to convert the Parties' separate systems into a single system and the expected features and benefits of the Platform.

In anticipation of the merger, the Parties have initiated the start of the IT assessment by creating an IT Functional Team, which has begun assessing the IT assets of each the merging entities, including applications, infrastructure, and IT contract portfolios to determine gaps. When this assessment is completed, the Team will form recommendations and identify the required IT "stack" necessary to deliver a total solution. As IT systems cut across core competencies, the Parties anticipate these decisions being very challenging. The electronic health records ("EHR") and Health Information Exchange ("HIE") capabilities will be needed to support almost all of the foundational areas. The Parties plan to invest in analytic capabilities that will be needed for various areas, including management, quality outcomes management, and accounting.

The Common Clinical IT Platform will serve as the backbone of the NHS IT System. This common platform will allow providers for all NHS services the ability to quickly obtain full access to patient records at the point of care and will also facilitate the development and increased adoption of best practices and evidence-based medicine recommended by the Clinical Council. In its Application, NHS has committed to the investment of approximately \$150 million over ten years to ensure a Common Clinical IT Platform is implemented and interoperability is available among the New Health System's hospitals, physicians, and related services. The cost of implementation of a Common Clinical IT Platform is built into the capital model for the NHS. Standardized order sets, collection of data and standardization of data sharing with physicians are all benefits that would be immediately achieved with the Common Clinical IT Platform once fully implemented. The unified platform will replace the four separate platforms that Wellmont and Mountain States currently operate. The common platform and standardization of process improvements will provide better and almost complete clinical transparency for our patients, their families, and clinicians. It is anticipated that the IT Functional Team will develop a Request for Proposals for the new Common Clinical IT Platform prior to closing. It is intended that the Team will select an appropriate platform in the first year after closing and begin functional preparation for implementation with particular emphasis placed on organizational responsibility alignment, staffing needs assessment, and timeline development.

The Common Clinical IT Platform will connect all NHS providers and allow them the ability to quickly obtain full access to patient records at the point of care. The IT Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by NHS. The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care. This will enable NHS to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, NHS has committed to participating in an HIE open to community providers and will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians.

This region-wide HIE, which will include the New Health System, independent providers, medical groups and facilities in an effective collaborative model, will encourage and support patient and provider connectivity to the integrated information system. In conjunction with the Common Clinical IT Platform, the HIE can be utilized for the management of shared patients between physicians, hospitals, and outpatient settings especially for the avoidance of unnecessary duplication of testing

and care coordination to close care gaps. Among other benefits, the seamless sharing of this information will reduce unnecessary cost, mitigate risk to patients and enable improved productivity among providers. After the transaction, NHS will commit financial resources to the utilization of an effective HIE. These incremental resources will contribute to the sustainability of an effective HIE model.

The New Health System's enhanced IT system will allow improved reporting of quality outcomes. In addition to the CMS core measures, patient satisfaction data, benchmarking data, and high priority measures, NHS commits to the extensive public and timely reporting on its website the following:

- Surgical site infection rates for each facility annually
- The 10 most frequent surgical procedures performed (by number of cases) at each ASC in Ballad Health annually
- The following information annually by facility, aggregated for the facility across the DRGs that comprise 80% of the discharges from Ballad Health facilities:
 - + severity adjusted cost/case,
 - + length of stay,
 - + mortality rate, and
 - + Thirty-day readmission rate.
- The New Health System will select a third-party vendor and provide data for the vendor to analyze the severity adjusted measures and post them on the New Health System's website.
- The quality measures for the top 10 DRGs aggregated across the system annually. The Parties note that the New Health System's Common Clinical IT Platform will enable it to generate and report more data more quickly than the Parties are currently able to do.

Each of these components is a critical part of the New Health System's comprehensive IT strategy enabling it to transform into a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement to the communities served by the combined system. While the detailed timeline has not been developed yet, the Parties believe the planning that has gone into the detailed process outlined in Exhibit Q-2C will allow the NHS to implement this complex but vital part of its new health care delivery model in a timely, effective way.

LIST OF EXHIBITS FOR RESPONSE #10

SECTION V

Exhibit Number	Description
F-5	Joint Community Health Work Groups Initial Reports
I-1A	MSHA Description of Insurance Program *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
N-8A	MSHA Governmental Requests – 1– *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
N-8B	MSHA Governmental Requests – 2– *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
N-8E	Joint Governmental Requests
N-9B	MSHA Responses to Governmental Requests – 2– *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
N-9C	MSHA Responses to Governmental Requests – 3
N-9F	WHS Responses to Governmental Requests – 3

Cooperative Agreement Application
Response #10 dated February 9, 2017
For Request Dated December 22, 2016

N-10A	MSHA List of Strategic Plans and MSHA Existing & Future Business Plans *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
N-10B	MSHA Strategic Plan Data *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
O-1A	WHS’s Services at Virginia Hospitals
O-1B	MSHA Services at Virginia Hospitals
O-10A	MSHA Revenue and Expense Statistics *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).
P-3A	MSHA Patients Managed by Employed Physicians *This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia’s Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

**Cooperative Agreement Application
Response #10 dated February 9, 2017
For Request Dated December 22, 2016**

STATE OF TENNESSEE

Office of the Attorney General



HERBERT H. SLATERY III
ATTORNEY GENERAL AND REPORTER

P.O. BOX 20207, NASHVILLE, TN 37202
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April 20, 2016

BY U.S. MAIL and E-MAIL

Robert E. Cooper, Jr.
BASS BERRY & SIMS
150 Third Avenue South
Suite 2800
Nashville, TN 37201

Re: Mountain States Health Alliance Request for Confidential Treatment of Certain Provisions of the Application for Certificate of Public Advantage

Dear General Cooper:

This Office is in receipt of your March 24, 2016 letter requesting that your client, Mountain States Health Alliance (MSHA), be allowed to submit certain information required as part of the Certificate of Public Advantage (COPA) application confidentially. We have reviewed the documents you have identified in your letter and have fully discussed these documents with the Department of Health.

As a result of that review and discussions, we have determined that, in order to avoid federal antitrust exposure and competitive commercial harm, the following documents should be maintained as confidential:

- The two exhibits identified in your list as Exhibits 11.6
- The first five exhibits identified in your list as Exhibits 11.11

However, we would note that to the extent any of the documents contain information that has already been made public, we will not be able to maintain that information as confidential.

With respect to the remaining documents identified as Exhibits 11.11, we need more information before we can make a determination as to whether these documents should be maintained as confidential. Particularly, with respect to the documents identified as "Market Review", it would be helpful if we could conduct an *in camera* inspection of a sample document

to get a better understanding of the scope of these documents. With respect to the remaining documents, we simply need more detail concerning these documents—what information they contain that needs to be maintained as confidential. In particular, one of the documents is simply identified as “Mountain States Foundation” and we are somewhat at a loss to understand why information concerning this nonprofit entity needs to remain confidential. It may be that a meeting where we have the opportunity to view these documents along with a sample “Market Review” *in camera* may be the most helpful and expeditious way to assist our Office in making a determination as to the confidentiality of these documents and we are certainly willing to arrange such a meeting as soon as possible.

Additionally, based on our initial review of the COPA application and our discussions with the Department, we have identified a number of additional documents and/or information that we believe are necessary in order for us to conduct a complete and thorough evaluation of the proposed transaction. We fully recognize that some of the documents we are requesting may also need to be maintained as confidential and are glad to discuss further with you.

Below is a list of the additional documents/information we are requesting. Please note that this list is not exhaustive and that we may be requesting additional documents or information.

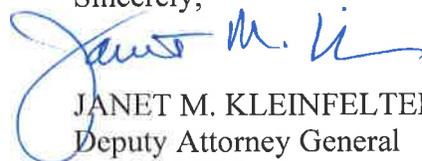
- Documents relating to both merging parties’ plans for electronic health records systems, including documents showing the current system each party is using, plans to convert to a single records system, including a timeline, the expected benefits of the system versus using the health information exchange, and any consulting reports.
- Documents relating to health information exchanges (HIE) used by each party, including current usage, how information is shared, fees or costs paid to use the system, how many other providers (e.g., physicians, outpatient facilities, hospitals) currently use the system, how records are shared, the extent of patient records included in the exchange, and any consulting reports.
- Documents relating to any plans to create the Common Clinical IT platform, including any internal analyses and consultant reports.
- Documents relating to any culture audits, governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.
- Documents relating to how past physician acquisitions and physician contracts or affiliations have contributed to each party’s ability to enter into risk based and/or value based contracts.
- Documents filed with the Health Services Development Agency within the past five (5) years.
- Documents relating to each party’s accountable care organization (ACO) or shared savings arrangement, including whether the ACO or shared savings arrangement is hospital-led or physician led. Also for each physician, mid-level practitioner, or other health profession

on whose behalf a party negotiates with health insurance plans or is reimbursed based on a health insurance plan's rate schedule with the party, or with whom a party has an affiliation or contractual, please provide the following information:

- Name;
 - Medical specialties;
 - Current office practice address(es);
 - National provider identification (NPI) number and any other uniform physician identification number;
 - Employer and group NPI for that employer;
 - Whether he or she has an affiliation agreement with the party (e.g., IPA, ACO or any other affiliation or contractual arrangement) and the type of arrangement;
 - Date on which he or she was acquired, employed by, and/or affiliated with the merging party; and
 - The number of patients he or she treated each year.
- Documents relating to the party's existing and future relationship with East Tennessee State University and any other college or university.
 - Documents/information relating to the hospital bed count for competing hospitals in the geographic region.
 - Documents/information relating to volume outcomes, in particular, what specialties or sub-specialties do the parties intend to consolidate as part of the proposed transaction.
 - Documents relating to the party's current use of tele-medicine in the area as well as plans for future use, including any grant money obtained to develop or deploy any systems for utilizing tele-medicine.
 - Documents relating to current efforts regarding physician recruitment, including what difficulties the party has encountered and whether these difficulties will be alleviated or lessened as a result of the proposed transaction.
 - Documents relating to the current duplication of services, including identification of those services that are currently being duplicated and that will be reduced or eliminated as a part of or due to the proposed transaction.

Please let us know if you have any questions concerns these requests or would like to discuss further.

Sincerely,



JANET M. KLEINFELTER
Deputy Attorney General

cc: Jane Young
Malaka Watson