APPENDIX E

12. Governmental Filings. Attach as Appendix E all government filings with respect to the Transaction, including all amendments, appendices, and attachments, and each report or document provided to each federal, state, or local governmental entity regarding the Transaction. Include copies of forms provided to each such entity, the answers to information or questions on such forms, and each attachment submitted in connection therewith.

This Transaction is not a "sale," as it does not involve the transfer of assets and will not generate any proceeds at closing. The Transaction involves the affiliation of two separate nonprofit entities – Mountain States Health Alliance and Wellmont Health System – by converting them into membership nonprofit corporations and creating a new nonprofit entity, Newco, that will be the sole member of each. Because the Transaction will not constitute a "change of ownership," Mountain States does not anticipate having to file change of ownership applications or reapply for licensure for its facilities. However, hospitals and other health care facilities owned or controlled by Mountain States may be required to file notices or information updates with respect to existing licenses and permits, which are listed in this Appendix E under the "Licenses and Permits" heading. Specifically, Mountain States will file a Form CMS-855A for a "change of information" for each of its hospitals and will likely make equivalent filings for hospitals to the Tennessee and Virginia Medicaid programs. Mountain States will produce such filings upon request.

Index:

1. IRS filings

- IRS Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code, with Attachments

- IRS Form 2848, Power of Attorney and Declaration of Representative, March 7, 2016

[*Following Attachment is Confidential***]**

[This section left intentionally blank.]

[*End of Confidential Attachment***]**

3. Supplemental Virginia COPA filings

- Response to Southwest Virginia Health Authority ("SWVHA") Request of May 27, 2016 dated July 13, 2016

- Supplemental Response to SWVHA Request of May 27, 2016 dated July 25, 2016

[*Following Attachment is Confidential***]**

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[*End of Attachment is Confidential***]**

A new interactive version of Form 1023 is available at StayExempt.irs.gov. It includes prerequisite questions, auto-calculated fields, help buttons and links to relevant information.

Form **1023** (Rev. December 2013)
Department of the Treasury
Internal Revenue Service

Application for Recognition of Exemption
Under Section 501(c)(3) of the Internal Revenue Code

▶ (Use with the June 2006 revision of the Instructions for Form 1023 and the current Notice 1382)

(00)

OMB No. 1545-0056

Note: *If exempt status is approved, this application will be open for public inspection.*

Use the instructions to complete this application and for a definition of all ***bold*** *items.* For additional help, call IRS Exempt Organizations Customer Account Services toll-free at 1-877-829-5500. Visit our website at **www.irs.gov** for forms and publications. If the required information and documents are not submitted with payment of the appropriate user fee, the application may be returned to you.

Attach additional sheets to this application if you need more space to answer fully. Put your name and EIN on each sheet and identify each answer by Part and line number. Complete Parts I - XI of Form 1023 and submit only those Schedules (A through H) that apply to you.

Part I Identification of Applicant

1 Full name of organization (exactly as it appears in your **organizing document**)

Newco, Inc.

2 c/o Name (if applicable)

3 **Mailing address** (Number and street) (see instructions)

211 Commerce St

Room/Suite: 800

4 Employer Identification Number (EIN)

61-1771290

City or town, state or country, and ZIP + 4

Nashville, TN 37201-1817

5 Month the annual accounting period ends (01 – 12)

6

6 Primary contact (officer, director, trustee, or **authorized representative**)

a Name: Jon D. Seawright, 4268 I55 North, Jackson, MS 39211

b Phone: 601.351.8921

c Fax: (optional) 601.974.8921

7 Are you represented by an authorized representative, such as an attorney or accountant? If "Yes," provide the authorized representative's name, and the name and address of the authorized representative's firm. Include a completed Form 2848, *Power of Attorney and Declaration of Representative,* with your application if you would like us to communicate with your representative.

☑ **Yes** ☐ **No**

8 Was a person who is not one of your officers, directors, trustees, employees, or an authorized representative listed in line 7, paid, or promised payment, to help plan, manage, or advise you about the structure or activities of your organization, or about your financial or tax matters? If "Yes," provide the person's name, the name and address of the person's firm, the amounts paid or promised to be paid, and describe that person's role.

☐ **Yes** ☑ **No**

9a Organization's website:

b Organization's email: (optional)

10 Certain organizations are not required to file an information return (Form 990 or Form 990-EZ). If you are granted tax-exemption, are you claiming to be excused from filing Form 990 or Form 990-EZ? If "Yes," explain. See the instructions for a description of organizations not required to file Form 990 or Form 990-EZ.

☐ **Yes** ☑ **No**

11 Date incorporated if a corporation, or formed, if other than a corporation. (MM/DD/YYYY) 09 / 11 / 2015

12 Were you formed under the laws of a **foreign country?** If "Yes," state the country.

☐ **Yes** ☑ **No**

MSHA0446

Part II Organizational Structure

You must be a corporation (including a limited liability company), an unincorporated association, or a trust to be tax exempt. (See instructions.) **DO NOT file this form unless you can check "Yes" on lines 1, 2, 3, or 4.**

1	Are you a **corporation**? If "Yes," attach a copy of your articles of incorporation showing **certification of filing** with the appropriate state agency. Include copies of any amendments to your articles and be sure they also show state filing certification. See Attachment A	☑ Yes	☐ No
2	Are you a **limited liability company (LLC)**? If "Yes," attach a copy of your articles of organization showing certification of filing with the appropriate state agency. Also, if you adopted an operating agreement, attach a copy. Include copies of any amendments to your articles and be sure they show state filing certification. Refer to the instructions for circumstances when an LLC should not file its own exemption application.	☐ Yes	☑ No
3	Are you an **unincorporated association**? If "Yes," attach a copy of your articles of association, constitution, or other similar organizing document that is dated and includes at least two signatures. Include signed and dated copies of any amendments.	☐ Yes	☑ No
4a	Are you a **trust**? If "Yes," attach a signed and dated copy of your trust agreement. Include signed and dated copies of any amendments.	☐ Yes	☑ No
b	Have you been funded? If "No," explain how you are formed without anything of value placed in trust.	☐ Yes	☐ No
5	Have you adopted **bylaws**? If "Yes," attach a current copy showing date of adoption. If "No," explain how your officers, directors, or trustees are selected. See Attachment B	☑ Yes	☐ No

Part III Required Provisions in Your Organizing Document

The following questions are designed to ensure that when you file this application, your organizing document contains the required provisions to meet the organizational test under section 501(c)(3). Unless you can check the boxes in both lines 1 and 2, your organizing document does not meet the organizational test. **DO NOT file this application until you have amended your organizing document**. Submit your original and amended organizing documents (showing state filing certification if you are a corporation or an LLC) with your application.

1	Section 501(c)(3) requires that your organizing document state your exempt purpose(s), such as charitable, religious, educational, and/or scientific purposes. Check the box to confirm that your organizing document meets this requirement. Describe specifically where your organizing document meets this requirement, such as a reference to a particular article or section in your organizing document. Refer to the instructions for exempt purpose language. Location of Purpose Clause (Page, Article, and Paragraph): **See Attachment C**	☑
2a	Section 501(c)(3) requires that upon dissolution of your organization, your remaining assets must be used exclusively for exempt purposes, such as charitable, religious, educational, and/or scientific purposes. Check the box on line 2a to confirm that your organizing document meets this requirement by express provision for the distribution of assets upon dissolution. If you rely on state law for your dissolution provision, do not check the box on line 2a and go to line 2c.	☑
2b	If you checked the box on line 2a, specify the location of your dissolution clause (Page, Article, and Paragraph). Do not complete line 2c if you checked box 2a. **See Attachment C**	
2c	See the instructions for information about the operation of state law in your particular state. Check this box if you rely on operation of state law for your dissolution provision and indicate the state: _____	☐

Part IV Narrative Description of Your Activities See Attachment D

Using an attachment, describe your *past, present,* and *planned* activities in a narrative. If you believe that you have already provided some of this information in response to other parts of this application, you may summarize that information here and refer to the specific parts of the application for supporting details. You may also attach representative copies of newsletters, brochures, or similar documents for supporting details to this narrative. Remember that if this application is approved, it will be open for public inspection. Therefore, your narrative description of activities should be thorough and accurate. Refer to the instructions for information that must be included in your description.

Part V Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors

1a List the names, titles, and mailing addresses of all of your officers, directors, and trustees. For each person listed, state their total annual **compensation**, or proposed compensation, for all services to the organization, whether as an officer, employee, or other position. Use actual figures, if available. Enter "none" if no compensation is or will be paid. If additional space is needed, attach a separate sheet. Refer to the instructions for information on what to include as compensation.

Name	Title	Mailing address	Compensation amount (annual actual or estimated)
See Attachment E			

Part V **Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors** *(Continued)*

b List the names, titles, and mailing addresses of each of your five highest compensated employees who receive or will receive compensation of more than $50,000 per year. Use the actual figure, if available. Refer to the instructions for information on what to include as compensation. Do not include officers, directors, or trustees listed in line 1a.

Name	Title	Mailing address	Compensation amount (annual actual or estimated)
See Attachment E			

c List the names, names of businesses, and mailing addresses of your five highest compensated **independent contractors** that receive or will receive compensation of more than $50,000 per year. Use the actual figure, if available. Refer to the instructions for information on what to include as compensation.

Name	Title	Mailing address	Compensation amount (annual actual or estimated)
See Attachment E			

The following "Yes" or "No" questions relate to *past, present, or planned* relationships, transactions, or agreements with your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed in lines 1a, 1b, and 1c.

2a Are any of your officers, directors, or trustees **related** to each other through **family** or **business relationships**? If "Yes," identify the individuals and explain the relationship. ☐ **Yes** ☑ **No**

b Do you have a business relationship with any of your officers, directors, or trustees other than through their position as an officer, director, or trustee? If "Yes," identify the individuals and describe the business relationship with each of your officers, directors, or trustees. ☐ **Yes** ☑ **No**

c Are any of your officers, directors, or trustees related to your highest compensated employees or highest compensated independent contractors listed on lines 1b or 1c through family or business relationships? If "Yes," identify the individuals and explain the relationship. ☐ **Yes** ☑ **No**

3a For each of your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed on lines 1a, 1b, or 1c, attach a list showing their name, qualifications, average hours worked, and duties.

b Do any of your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed on lines 1a, 1b, or 1c receive compensation from any other organizations, whether tax exempt or taxable, that are related to you through **common control**? If "Yes," identify the individuals, explain the relationship between you and the other organization, and describe the compensation arrangement. ☐ **Yes** ☑ **No**

4 In establishing the compensation for your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed on lines 1a, 1b, and 1c, the following practices are recommended, although they are not required to obtain exemption. Answer "Yes" to all the practices you use.

a Do you or will the individuals that approve compensation arrangements follow a conflict of interest policy? ☑ **Yes** ☐ **No**

b Do you or will you approve compensation arrangements in advance of paying compensation? ☑ **Yes** ☐ **No**

c Do you or will you document in writing the date and terms of approved compensation arrangements? ☑ **Yes** ☐ **No**

Part V **Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors** *(Continued)*

d	Do you or will you record in writing the decision made by each individual who decided or voted on compensation arrangements?	☑ Yes	☐ No
e	Do you or will you approve compensation arrangements based on information about compensation paid by **similarly situated** taxable or tax-exempt organizations for similar services, current compensation surveys compiled by independent firms, or actual written offers from similarly situated organizations? Refer to the instructions for Part V, lines 1a, 1b, and 1c, for information on what to include as compensation.	☑ Yes	☐ No
f	Do you or will you record in writing both the information on which you relied to base your decision and its source?	☑ Yes	☐ No
g	If you answered "No" to any item on lines 4a through 4f, describe how you set compensation that is **reasonable** for your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed in Part V, lines 1a, 1b, and 1c.		
5a	Have you adopted a **conflict of interest policy** consistent with the sample conflict of interest policy in Appendix A to the instructions? If "Yes," provide a copy of the policy and explain how the policy has been adopted, such as by resolution of your governing board. If "No," answer lines 5b and 5c.	☑ Yes	☐ No
b	What procedures will you follow to assure that persons who have a conflict of interest will not have influence over you for setting their own compensation?	See Attachment F	
c	What procedures will you follow to assure that persons who have a conflict of interest will not have influence over you regarding business deals with themselves?		
	Note: A conflict of interest policy is recommended though it is not required to obtain exemption. Hospitals, see Schedule C, Section I, line 14.		
6a	Do you or will you compensate any of your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed in lines 1a, 1b, or 1c through **non-fixed payments**, such as discretionary bonuses or revenue-based payments? If "Yes," describe all non-fixed compensation arrangements, including how the amounts are determined, who is eligible for such arrangements, whether you place a limitation on total compensation, and how you determine or will determine that you pay no more than reasonable compensation for services. Refer to the instructions for Part V, lines 1a, 1b, and 1c, for information on what to include as compensation.	☑ Yes	☐ No
		See Attachment G	
b	Do you or will you compensate any of your employees, other than your officers, directors, trustees, or your five highest compensated employees who receive or will receive compensation of more than $50,000 per year, through non-fixed payments, such as discretionary bonuses or revenue-based payments? If "Yes," describe all non-fixed compensation arrangements, including how the amounts are or will be determined, who is or will be eligible for such arrangements, whether you place or will place a limitation on total compensation, and how you determine or will determine that you pay no more than reasonable compensation for services. Refer to the instructions for Part V, lines 1a, 1b, and 1c, for information on what to include as compensation.	☐ Yes	☑ No
7a	Do you or will you purchase any goods, services, or assets from any of your officers, directors, trustees, highest compensated employees, or highest compensated independent contractors listed in lines 1a, 1b, or 1c? If "Yes," describe any such purchase that you made or intend to make, from whom you make or will make such purchases, how the terms are or will be negotiated at **arm's length**, and explain how you determine or will determine that you pay no more than **fair market value**. Attach copies of any written contracts or other agreements relating to such purchases.	☐ Yes	☑ No
b	Do you or will you sell any goods, services, or assets to any of your officers, directors, trustees, highest compensated employees, or highest compensated independent contractors listed in lines 1a, 1b, or 1c? If "Yes," describe any such sales that you made or intend to make, to whom you make or will make such sales, how the terms are or will be negotiated at arm's length, and explain how you determine or will determine you are or will be paid at least fair market value. Attach copies of any written contracts or other agreements relating to such sales.	☐ Yes	☑ No
8a	Do you or will you have any leases, contracts, loans, or other agreements with your officers, directors, trustees, highest compensated employees, or highest compensated independent contractors listed in lines 1a, 1b, or 1c? If "Yes," provide the information requested in lines 8b through 8f.	☐ Yes	☑ No
b	Describe any written or oral arrangements that you made or intend to make.		
c	Identify with whom you have or will have such arrangements.		
d	Explain how the terms are or will be negotiated at arm's length.		
e	Explain how you determine you pay no more than fair market value or you are paid at least fair market value.		
f	Attach copies of any signed leases, contracts, loans, or other agreements relating to such arrangements.		
9a	Do you or will you have any leases, contracts, loans, or other agreements with any organization in which any of your officers, directors, or trustees are also officers, directors, or trustees, or in which any individual officer, director, or trustee owns more than a 35% interest? If "Yes," provide the information requested in lines 9b through 9f.	☑ Yes	☐ No
		See Attachment H	

Part V **Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors** *(Continued)*

b Describe any written or oral arrangements you made or intend to make.

c Identify with whom you have or will have such arrangements.

d Explain how the terms are or will be negotiated at arm's length.

e Explain how you determine or will determine you pay no more than fair market value or that you are paid at least fair market value.

f Attach a copy of any signed leases, contracts, loans, or other agreements relating to such arrangements.

Part VI **Your Members and Other Individuals and Organizations That Receive Benefits From You**

The following "Yes" or "No" questions relate to goods, services, and funds you provide to individuals and organizations as part of your activities. Your answers should pertain to *past, present,* and *planned* activities. (See instructions.)

1a In carrying out your exempt purposes, do you provide goods, services, or funds to individuals? If "Yes," describe each program that provides goods, services, or funds to individuals. ☐ **Yes** ☑ **No**

b In carrying out your exempt purposes, do you provide goods, services, or funds to organizations? If "Yes," describe each program that provides goods, services, or funds to organizations. ☑ **Yes** ☐ **No**

See Attachment I

2 Do any of your programs limit the provision of goods, services, or funds to a specific individual or group of specific individuals? For example, answer "Yes," if goods, services, or funds are provided only for a particular individual, your members, individuals who work for a particular employer, or graduates of a particular school. If "Yes," explain the limitation and how recipients are selected for each program. ☐ **Yes** ☑ **No**

3 Do any individuals who receive goods, services, or funds through your programs have a family or business relationship with any officer, director, trustee, or with any of your highest compensated employees or highest compensated independent contractors listed in Part V, lines 1a, 1b, and 1c? If "Yes," explain how these related individuals are eligible for goods, services, or funds. ☐ **Yes** ☑ **No**

Part VII **Your History**

The following "Yes" or "No" questions relate to your history. (See instructions.)

1 Are you a **successor** to another organization? Answer "Yes," if you have taken or will take over the activities of another organization; you took over 25% or more of the fair market value of the net assets of another organization; or you were established upon the conversion of an organization from for-profit to non-profit status. If "Yes," complete Schedule G. ☐ **Yes** ☑ **No**

2 Are you submitting this application more than 27 months after the end of the month in which you were legally formed? If "Yes," complete Schedule E. ☐ **Yes** ☑ **No**

Part VIII **Your Specific Activities**

The following "Yes" or "No" questions relate to specific activities that you may conduct. Check the appropriate box. Your answers should pertain to *past, present,* and *planned* activities. (See instructions.)

1 Do you support or oppose candidates in **political campaigns** in any way? If "Yes," explain. ☐ **Yes** ☑ **No**

2a Do you attempt to **influence legislation**? If "Yes," explain how you attempt to influence legislation and complete line 2b. If "No," go to line 3a. ☑ **Yes** ☐ **No**

See Attachment J

b Have you made or are you making an **election** to have your legislative activities measured by expenditures by filing Form 5768? If "Yes," attach a copy of the Form 5768 that was already filed or attach a completed Form 5768 that you are filing with this application. If "No," describe whether your attempts to influence legislation are a substantial part of your activities. Include the time and money spent on your attempts to influence legislation as compared to your total activities. ☐ **Yes** ☑ **No**

See Attachment J

3a Do you or will you operate bingo or **gaming** activities? If "Yes," describe who conducts them, and list all revenue received or expected to be received and expenses paid or expected to be paid in operating these activities. **Revenue and expenses** should be provided for the time periods specified in Part IX, Financial Data. ☐ **Yes** ☑ **No**

b Do you or will you enter into contracts or other agreements with individuals or organizations to conduct bingo or gaming for you? If "Yes," describe any written or oral arrangements that you made or intend to make, identify with whom you have or will have such arrangements, explain how the terms are or will be negotiated at arm's length, and explain how you determine or will determine you pay no more than fair market value or you will be paid at least fair market value. Attach copies or any written contracts or other agreements relating to such arrangements. ☐ **Yes** ☑ **No**

c List the states and local jurisdictions, including Indian Reservations, in which you conduct or will conduct gaming or bingo.

Part VIII Your Specific Activities *(Continued)*

4a Do you or will you undertake **fundraising**? If "Yes," check all the fundraising programs you do or will conduct. (See instructions.) ☐ Yes ☑ No

- ☐ mail solicitations
- ☐ email solicitations
- ☐ personal solicitations
- ☐ vehicle, boat, plane, or similar donations
- ☐ foundation grant solicitations
- ☐ phone solicitations
- ☐ accept donations on your website
- ☐ receive donations from another organization's website
- ☐ government grant solicitations
- ☐ Other

Attach a description of each fundraising program.

b Do you or will you have written or oral contracts with any individuals or organizations to raise funds for you? If "Yes," describe these activities. Include all revenue and expenses from these activities and state who conducts them. Revenue and expenses should be provided for the time periods specified in Part IX, Financial Data. Also, attach a copy of any contracts or agreements. ☐ Yes ☑ No

c Do you or will you engage in fundraising activities for other organizations? If "Yes," describe these arrangements. Include a description of the organizations for which you raise funds and attach copies of all contracts or agreements. ☐ Yes ☑ No

d List all states and local jurisdictions in which you conduct fundraising. For each state or local jurisdiction listed, specify whether you fundraise for your own organization, you fundraise for another organization, or another organization fundraises for you.

e Do you or will you maintain separate accounts for any contributor under which the contributor has the right to advise on the use or distribution of funds? Answer "Yes" if the donor may provide advice on the types of investments, distributions from the types of investments, or the distribution from the donor's contribution account. If "Yes," describe this program, including the type of advice that may be provided and submit copies of any written materials provided to donors. ☐ Yes ☑ No

5 Are you **affiliated** with a governmental unit? If "Yes," explain. ☐ Yes ☑ No

6a Do you or will you engage in **economic development**? If "Yes," describe your program. ☐ Yes ☑ No

b Describe in full who benefits from your economic development activities and how the activities promote exempt purposes.

7a Do or will persons other than your employees or volunteers **develop** your facilities? If "Yes," describe each facility, the role of the developer, and any business or family relationship(s) between the developer and your officers, directors, or trustees. ☐ Yes ☑ No

b Do or will persons other than your employees or volunteers **manage** your activities or facilities? If "Yes," describe each activity and facility, the role of the manager, and any business or family relationship(s) between the manager and your officers, directors, or trustees. ☐ Yes ☑ No

c If there is a business or family relationship between any manager or developer and your officers, directors, or trustees, identify the individuals, explain the relationship, describe how contracts are negotiated at arm's length so that you pay no more than fair market value, and submit a copy of any contracts or other agreements.

8 Do you or will you enter into **joint ventures**, including partnerships or **limited liability companies** treated as partnerships, in which you share profits and losses with partners other than section 501(c)(3) organizations? If "Yes," describe the activities of these joint ventures in which you participate. ☐ Yes ☑ No

9a Are you applying for exemption as a childcare organization under section 501(k)? If "Yes," answer lines 9b through 9d. If "No," go to line 10. ☐ Yes ☑ No

b Do you provide child care so that parents or caretakers of children you care for can be **gainfully employed** (see instructions)? If "No," explain how you qualify as a childcare organization described in section 501(k). ☐ Yes ☐ No

c Of the children for whom you provide child care, are 85% or more of them cared for by you to enable their parents or caretakers to be gainfully employed (see instructions)? If "No," explain how you qualify as a childcare organization described in section 501(k). ☐ Yes ☐ No

d Are your services available to the general public? If "No," describe the specific group of people for whom your activities are available. Also, see the instructions and explain how you qualify as a childcare organization described in section 501(k). ☐ Yes ☐ No

10 Do you or will you publish, own, or have rights in music, literature, tapes, artworks, choreography, scientific discoveries, or other **intellectual property**? If "Yes," explain. Describe who owns or will own any copyrights, patents, or trademarks, whether fees are or will be charged, how the fees are determined, and how any items are or will be produced, distributed, and marketed. ☐ Yes ☑ No

Part VIII Your Specific Activities *(Continued)*

11	Do you or will you accept contributions of: real property; conservation easements; closely held securities; intellectual property such as patents, trademarks, and copyrights; works of music or art; licenses; royalties; automobiles, boats, planes, or other vehicles; or collectibles of any type? If "Yes," describe each type of contribution, any conditions imposed by the donor on the contribution, and any agreements with the donor regarding the contribution.	☐ Yes	☑ No
12a	Do you or will you operate in a **foreign country** or **countries?** If "Yes," answer lines 12b through 12d. If "No," go to line 13a.	☐ Yes	☑ No
b	Name the foreign countries and regions within the countries in which you operate.		
c	Describe your operations in each country and region in which you operate.		
d	Describe how your operations in each country and region further your exempt purposes.		
13a	Do you or will you make grants, loans, or other distributions to organization(s)? If "Yes," answer lines 13b through 13g. If "No," go to line 14a. See Attachment K	☑ Yes	☐ No
b	Describe how your grants, loans, or other distributions to organizations further your exempt purposes.		
c	Do you have written contracts with each of these organizations? If "Yes," attach a copy of each contract.	☐ Yes	☐ No
d	Identify each recipient organization and any **relationship** between you and the recipient organization. See Attachment K		
e	Describe the records you keep with respect to the grants, loans, or other distributions you make.		
f	Describe your selection process, including whether you do any of the following:		
	(i) Do you require an application form? If "Yes," attach a copy of the form.	☐ Yes	☐ No
	(ii) Do you require a grant proposal? If "Yes," describe whether the grant proposal specifies your responsibilities and those of the grantee, obligates the grantee to use the grant funds only for the purposes for which the grant was made, provides for periodic written reports concerning the use of grant funds, requires a final written report and an accounting of how grant funds were used, and acknowledges your authority to withhold and/or recover grant funds in case such funds are, or appear to be, misused.	☐ Yes	☐ No
g	Describe your procedures for oversight of distributions that assure you the resources are used to further your exempt purposes, including whether you require periodic and final reports on the use of resources.		
14a	Do you or will you make grants, loans, or other distributions to foreign organizations? If "Yes," answer lines 14b through 14f. If "No," go to line 15.	☐ Yes	☑ No
b	Provide the name of each foreign organization, the country and regions within a country in which each foreign organization operates, and describe any relationship you have with each foreign organization.		
c	Does any foreign organization listed in line 14b accept contributions earmarked for a specific country or specific organization? If "Yes," list all earmarked organizations or countries.	☐ Yes	☐ No
d	Do your contributors know that you have ultimate authority to use contributions made to you at your discretion for purposes consistent with your exempt purposes? If "Yes," describe how you relay this information to contributors.	☐ Yes	☐ No
e	Do you or will you make pre-grant inquiries about the recipient organization? If "Yes," describe these inquiries, including whether you inquire about the recipient's financial status, its tax-exempt status under the Internal Revenue Code, its ability to accomplish the purpose for which the resources are provided, and other relevant information.	☐ Yes	☐ No
f	Do you or will you use any additional procedures to ensure that your distributions to foreign organizations are used in furtherance of your exempt purposes? If "Yes," describe these procedures, including site visits by your employees or compliance checks by impartial experts, to verify that grant funds are being used appropriately.	☐ Yes	☐ No

Part VIII Your Specific Activities *(Continued)*

15	Do you have a **close connection** with any organizations? If "Yes," explain. See Attachment L	☑ **Yes**	☐ **No**
16	Are you applying for exemption as a **cooperative hospital service organization** under section 501(e)? If "Yes," explain.	☐ **Yes**	☑ **No**
17	Are you applying for exemption as a **cooperative service organization of operating educational organizations** under section 501(f)? If "Yes," explain.	☐ **Yes**	☑ **No**
18	Are you applying for exemption as a **charitable risk pool** under section 501(n)? If "Yes," explain.	☐ **Yes**	☑ **No**
19	Do you or will you operate a **school**? If "Yes," complete Schedule B. Answer "Yes," whether you operate a school as your main function or as a secondary activity.	☐ **Yes**	☑ **No**
20	Is your main function to provide **hospital** or **medical care**? If "Yes," complete Schedule C.	☐ **Yes**	☑ **No**
21	Do you or will you provide **low-income housing** or housing for the **elderly** or **handicapped**? If "Yes," complete Schedule F.	☐ **Yes**	☑ **No**
22	Do you or will you provide scholarships, fellowships, educational loans, or other educational grants to individuals, including grants for travel, study, or other similar purposes? If "Yes," complete Schedule H. **Note: Private foundations** may use Schedule H to request advance approval of individual grant procedures.	☐ **Yes**	☑ **No**

Part IX Financial Data See Attachment M

For purposes of this schedule, years in existence refer to completed tax years. If in existence 4 or more years, complete the schedule for the most recent 4 tax years. If in existence more than 1 year but less than 4 years, complete the statements for each year in existence and provide projections of your likely revenues and expenses based on a reasonable and good faith estimate of your future finances for a total of 3 years of financial information. If in existence less than 1 year, provide projections of your likely revenues and expenses for the current year and the 2 following years, based on a reasonable and good faith estimate of your future finances for a total of 3 years of financial information. (See instructions.)

A. Statement of Revenues and Expenses

	Type of revenue or expense	Current tax year	3 prior tax years or 2 succeeding tax years			
		(a) From ... To ...	(b) From ... To ...	(c) From ... To ...	(d) From ... To ...	(e) Provide Total for (a) through (d)
Revenues	1 Gifts, grants, and contributions received (do not include unusual grants)					
	2 Membership fees received					
	3 Gross investment income					
	4 Net unrelated business income					
	5 Taxes levied for your benefit					
	6 Value of services or facilities furnished by a governmental unit without charge (not including the value of services generally furnished to the public without charge)					
	7 Any revenue not otherwise listed above or in lines 9–12 below (attach an itemized list)					
	8 Total of lines 1 through 7					
	9 Gross receipts from admissions, merchandise sold or services performed, or furnishing of facilities in any activity that is related to your exempt purposes (attach itemized list)					
	10 Total of lines 8 and 9					
	11 Net gain or loss on sale of capital assets (attach schedule and see instructions)					
	12 **Unusual grants**					
	13 Total Revenue Add lines 10 through 12					
Expenses	14 Fundraising expenses					
	15 Contributions, gifts, grants, and similar amounts paid out (attach an itemized list)					
	16 Disbursements to or for the benefit of members (attach an itemized list)					
	17 Compensation of officers, directors, and trustees					
	18 Other salaries and wages					
	19 Interest expense					
	20 Occupancy (rent, utilities, etc.)					
	21 Depreciation and depletion					
	22 Professional fees					
	23 Any expense not otherwise classified, such as program services (attach itemized list)					
	24 Total Expenses Add lines 14 through 23					

Part IX Financial Data *(Continued)* See Attachment M

B. Balance Sheet (for your most recently completed tax year)

			Year End: (Whole dollars)
	Assets		
1	Cash	1	
2	Accounts receivable, net	2	
3	Inventories	3	
4	Bonds and notes receivable (attach an itemized list)	4	
5	Corporate stocks (attach an itemized list)	5	
6	Loans receivable (attach an itemized list)	6	
7	Other investments (attach an itemized list)	7	
8	Depreciable and depletable assets (attach an itemized list)	8	
9	Land	9	
10	Other assets (attach an itemized list)	10	
11	Total Assets (add lines 1 through 10)	11	
	Liabilities		
12	Accounts payable	12	
13	Contributions, gifts, grants, etc. payable	13	
14	Mortgages and notes payable (attach an itemized list)	14	
15	Other liabilities (attach an itemized list)	15	
16	Total Liabilities (add lines 12 through 15)	16	
	Fund Balances or Net Assets		
17	Total fund balances or net assets	17	
18	Total Liabilities and Fund Balances or Net Assets (add lines 16 and 17)	18	

19 Have there been any substantial changes in your assets or liabilities since the end of the period shown above? If "Yes," explain. ☐ **Yes** ☑ **No**

Part X Public Charity Status

Part X is designed to classify you as an organization that is either a **private foundation** or a **public charity**. Public charity status is a more favorable tax status than private foundation status. If you are a private foundation, Part X is designed to further determine whether you are a **private operating foundation**. (See instructions.)

1a Are you a private foundation? If "Yes," go to line 1b. If "No," go to line 5 and proceed as instructed. If you are unsure, see the instructions. ☐ **Yes** ☑ **No**

b As a private foundation, section 508(e) requires special provisions in your organizing document in addition to those that apply to all organizations described in section 501(c)(3). Check the box to confirm that your organizing document meets this requirement, whether by express provision or by reliance on operation of state law. Attach a statement that describes specifically where your organizing document meets this requirement, such as a reference to a particular article or section in your organizing document or by operation of state law. See the instructions, including Appendix B, for information about the special provisions that need to be contained in your organizing document. Go to line 2. ☐

2 Are you a private operating foundation? To be a private operating foundation you must engage directly in the active conduct of charitable, religious, educational, and similar activities, as opposed to indirectly carrying out these activities by providing grants to individuals or other organizations. If "Yes," go to line 3. If "No," go to the signature section of Part XI. ☐ **Yes** ☐ **No**

3 Have you existed for one or more years? If "Yes," attach financial information showing that you are a private operating foundation; go to the signature section of Part XI. If "No," continue to line 4. ☐ **Yes** ☐ **No**

4 Have you attached either (1) an affidavit or opinion of counsel, (including a written affidavit or opinion from a certified public accountant or accounting firm with expertise regarding this tax law matter), that sets forth facts concerning your operations and support to demonstrate that you are likely to satisfy the requirements to be classified as a private operating foundation; or (2) a statement describing your proposed operations as a private operating foundation? ☐ **Yes** ☐ **No**

5 If you answered "No" to line 1a, indicate the type of public charity status you are requesting by checking one of the choices below. You may check only one box.

The organization is not a private foundation because it is:

a 509(a)(1) and 170(b)(1)(A)(i)—a church or a convention or association of churches. Complete and attach Schedule A. ☐

b 509(a)(1) and 170(b)(1)(A)(ii)—a **school**. Complete and attach Schedule B. ☐

c 509(a)(1) and 170(b)(1)(A)(iii)—a **hospital**, a cooperative hospital service organization, or a medical research organization operated in conjunction with a hospital. Complete and attach Schedule C. ☐

d 509(a)(3)—an organization supporting either one or more organizations described in line 5a through c, f, g, or h or a publicly supported section 501(c)(4), (5), or (6) organization. Complete and attach Schedule D. ☑

Part X Public Charity Status *(Continued)*

e 509(a)(4)—an organization organized and operated exclusively for testing for public safety. ☐

f 509(a)(1) and 170(b)(1)(A)(iv)—an organization operated for the benefit of a college or university that is owned or operated by a governmental unit. ☐

g 509(a)(1) and 170(b)(1)(A)(vi)—an organization that receives a substantial part of its financial support in the form of contributions from publicly supported organizations, from a governmental unit, or from the general public. ☐

h 509(a)(2)—an organization that normally receives not more than one-third of its financial support from gross **investment income** and receives more than one-third of its financial support from contributions, membership fees, and gross receipts from activities related to its exempt functions (subject to certain exceptions). ☐

i A publicly supported organization, but unsure if it is described in 5g or 5h. The organization would like the IRS to decide the correct status. ☐

6 If you checked box g, h, or i in question 5 above, you must request either an **advance** or a **definitive ruling** by selecting one of the boxes below. Refer to the instructions to determine which type of ruling you are eligible to receive.

a Request for Advance Ruling: By checking this box and signing the consent, pursuant to section 6501(c)(4) of the Code you request an advance ruling and agree to extend the statute of limitations on the assessment of excise tax under section 4940 of the Code. The tax will apply only if you do not establish public support status at the end of the 5-year advance ruling period. The assessment period will be extended for the 5 advance ruling years to 8 years, 4 months, and 15 days beyond the end of the first year. You have the right to refuse or limit the extension to a mutually agreed-upon period of time or issue(s). Publication 1035, *Extending the Tax Assessment Period,* provides a more detailed explanation of your rights and the consequences of the choices you make. You may obtain Publication 1035 free of charge from the IRS web site at *www.irs.gov* or by calling toll-free 1-800-829-3676. Signing this consent will not deprive you of any appeal rights to which you would otherwise be entitled. If you decide not to extend the statute of limitations, you are not eligible for an advance ruling.

Consent Fixing Period of Limitations Upon Assessment of Tax Under Section 4940 of the Internal Revenue Code

For Organization

(Signature of Officer, Director, Trustee, or other authorized official) | (Type or print name of signer) | (Date)

(Type or print title or authority of signer)

For IRS Use Only

IRS Director, Exempt Organizations | (Date)

b Request for Definitive Ruling: Check this box if you have completed one tax year of at least 8 full months and you are requesting a definitive ruling. To confirm your public support status, answer line 6b(i) if you checked box g in line 5 above. Answer line 6b(ii) if you checked box h in line 5 above. If you checked box i in line 5 above, answer both lines 6b(i) and (ii). ☐

(i) (a) Enter 2% of line 8, column (e) on Part IX-A. Statement of Revenues and Expenses. _____

(b) Attach a list showing the name and amount contributed by each person, company, or organization whose gifts totaled more than the 2% amount. If the answer is "None," check this box. ☐

(ii) (a) For each year amounts are included on lines 1, 2, and 9 of Part IX-A. Statement of Revenues and Expenses, attach a list showing the name of and amount received from each **disqualified person.** If the answer is "None," check this box. ☐

(b) For each year amounts are included on line 9 of Part IX-A. Statement of Revenues and Expenses, attach a list showing the name of and amount received from each payer, other than a disqualified person, whose payments were more than the larger of (1) 1% of line 10, Part IX-A. Statement of Revenues and Expenses, or (2) $5,000. If the answer is "None," check this box. ☐

7 Did you receive any unusual grants during any of the years shown on Part IX-A. Statement of Revenues and Expenses? If "Yes," attach a list including the name of the contributor, the date and amount of the grant, a brief description of the grant, and explain why it is unusual. ☐ **Yes** ☐ **No**

Part XI User Fee Information

You must include a user fee payment with this application. It will not be processed without your paid user fee. If your average annual gross receipts have exceeded or will exceed $10,000 annually over a 4-year period, you must submit payment of $850. If your gross receipts have not exceeded or will not exceed $10,000 annually over a 4-year period, the required user fee payment is $400. See instructions for Part XI, for a definition of **gross receipts** over a 4-year period. Your check or money order must be made payable to the United States Treasury. *User fees are subject to change. Check our website at www.irs.gov and type "User Fee" in the keyword box, or call Customer Account Services at 1-877-829-5500 for current information.*

1	Have your annual gross receipts averaged or are they expected to average not more than $10,000? If "Yes," check the box on line 2 and enclose a user fee payment of $400 (Subject to change—see above). If "No," check the box on line 3 and enclose a user fee payment of $850 (Subject to change—see above).	☐ **Yes**	☑ **No**
2	Check the box if you have enclosed the reduced user fee payment of $400 (Subject to change).	☐	
3	Check the box if you have enclosed the user fee payment of $850 (Subject to change).	☑	

I declare under the penalties of perjury that I am authorized to sign this application on behalf of the above organization and that I have examined this application, including the accompanying schedules and attachments, and to the best of my knowledge it is true, correct, and complete.

Please Sign Here ▶

(Signature of Officer, Director, Trustee, or other authorized official)	Alan M. Levine (Type or print name of signer)	3/9/16 (Date)
	(Type or print title or authority of signer)	

Reminder: Send the completed Form 1023 Checklist with your filled-in-application.

Schedule D. Section 509(a)(3) Supporting Organizations

Section I Identifying Information About the Supported Organization(s)

1 State the names, addresses, and EINs of the supported organizations. If additional space is needed, attach a separate sheet.

Name	Address	EIN
See Attachment N		–
		–

2 Are all supported organizations listed in line 1 public charities under section 509(a)(1) or (2)? If "Yes," go to Section II. If "No," go to line 3. ☑ Yes ☐ No

3 Do the supported organizations have tax-exempt status under section 501(c)(4), 501(c)(5), or 501(c)(6)? ☐ Yes ☑ No

If "Yes," for each 501(c)(4), (5), or (6) organization supported, provide the following financial information:

- Part IX-A. Statement of Revenues and Expenses, lines 1–13 and
- Part X, lines 6b(ii)(a), 6b(ii)(b), and 7.

If "No," attach a statement describing how each organization you support is a public charity under section 509(a)(1) or (2).

Section II Relationship with Supported Organization(s)—Three Tests

To be classified as a supporting organization, an organization must meet one of three relationship tests:

Test 1: "Operated, supervised, or controlled by" one or more publicly supported organizations, or
Test 2: "Supervised or controlled in connection with" one or more publicly supported organizations, or
Test 3: "Operated in connection with" one or more publicly supported organizations.

1 Information to establish the "operated, supervised, or controlled by" relationship (Test 1)
Is a majority of your governing board or officers elected or appointed by the supported organization(s)? If "Yes," describe the process by which your governing board is appointed and elected; go to Section III. If "No," continue to line 2. ☐ Yes ☑ No

2 Information to establish the "supervised or controlled in connection with" relationship (Test 2)
Does a majority of your governing board consist of individuals who also serve on the governing board of the supported organization(s)? If "Yes," describe the process by which your governing board is appointed and elected; go to Section III. If "No," go to line 3. ☑ Yes ☐ No

See Attachment N

3 Information to establish the "operated in connection with" responsiveness test (Test 3)
Are you a trust from which the named supported organization(s) can enforce and compel an accounting under state law? If "Yes," explain whether you advised the supported organization(s) in writing of these rights and provide a copy of the written communication documenting this; go to Section II, line 5. If "No," go to line 4a. ☐ Yes ☐ No

4 Information to establish the alternative "operated in connection with" responsiveness test (Test 3)

a Do the officers, directors, trustees, or members of the supported organization(s) elect or appoint one or more of your officers, directors, or trustees? If "Yes," explain and provide documentation; go to line 4d, below. If "No," go to line 4b. ☐ Yes ☐ No

b Do one or more members of the governing body of the supported organization(s) also serve as your officers, directors, or trustees or hold other important offices with respect to you? If "Yes," explain and provide documentation; go to line 4d, below. If "No," go to line 4c. ☐ Yes ☐ No

c Do your officers, directors, or trustees maintain a close and continuous working relationship with the officers, directors, or trustees of the supported organization(s)? If "Yes," explain and provide documentation. ☐ Yes ☐ No

d Do the supported organization(s) have a significant voice in your investment policies, in the making and timing of grants, and in otherwise directing the use of your income or assets? If "Yes," explain and provide documentation. ☐ Yes ☐ No

e Describe and provide copies of written communications documenting how you made the supported organization(s) aware of your supporting activities.

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Schedule D. Section 509(a)(3) Supporting Organizations *(Continued)*

Section II Relationship with Supported Organization(s)—Three Tests *(Continued)*

5	Information to establish the "operated in connection with" integral part test (Test 3) Do you conduct activities that would otherwise be carried out by the supported organization(s)? If "Yes," explain and go to Section III. If "No," continue to line 6a.	☐ **Yes**	☐ **No**
6	Information to establish the alternative "operated in connection with" integral part test (Test 3)		
a	Do you distribute at least 85% of your annual **net income** to the supported organization(s)? If "Yes," go to line 6b. (See instructions.) If "No," state the percentage of your income that you distribute to each supported organization. Also explain how you ensure that the supported organization(s) are attentive to your operations.	☐ **Yes**	☐ **No**
b	How much do you contribute annually to each supported organization? Attach a schedule.		
c	What is the total annual revenue of each supported organization? If you need additional space, attach a list.		
d	Do you or the supported organization(s) **earmark** your funds for support of a particular program or activity? If "Yes," explain.	☐ **Yes**	☐ **No**
7a	Does your organizing document specify the supported organization(s) by name? If "Yes," state the article and paragraph number and go to Section III. If "No," answer line 7b.	☐ **Yes**	☐ **No**
b	Attach a statement describing whether there has been an historic and continuing relationship between you and the supported organization(s).		

Section III Organizational Test

1a	If you met relationship Test 1 or Test 2 in Section II, your organizing document must specify the supported organization(s) by name, or by naming a similar purpose or charitable class of beneficiaries. If your organizing document complies with this requirement, answer "Yes." If your organizing document does not comply with this requirement, answer "No," and see the instructions.	☑ **Yes**	☐ **No**
b	If you met relationship Test 3 in Section II, your organizing document must generally specify the supported organization(s) by name. If your organizing document complies with this requirement, answer "Yes," and go to Section IV. If your organizing document does not comply with this requirement, answer "No," and see the instructions.	☐ **Yes**	☐ **No**

Section IV Disqualified Person Test

You do not qualify as a supporting organization if you are **controlled** directly or indirectly by one or more **disqualified persons** (as defined in section 4946) other than **foundation managers** or one or more organizations that you support. Foundation managers who are also disqualified persons for another reason are disqualified persons with respect to you.

1a	Do any persons who are disqualified persons with respect to you, (except individuals who are disqualified persons only because they are foundation managers), appoint any of your foundation managers? If "Yes," (1) describe the process by which disqualified persons appoint any of your foundation managers, (2) provide the names of these disqualified persons and the foundation managers they appoint, and (3) explain how control is vested over your operations (including assets and activities) by persons other than disqualified persons.	☐ **Yes**	☑ **No**
b	Do any persons who have a family or business relationship with any disqualified persons with respect to you, (except individuals who are disqualified persons only because they are foundation managers), appoint any of your foundation managers? If "Yes," (1) describe the process by which individuals with a family or business relationship with disqualified persons appoint any of your foundation managers, (2) provide the names of these disqualified persons, the individuals with a family or business relationship with disqualified persons, and the foundation managers appointed, and (3) explain how control is vested over your operations (including assets and activities) in individuals other than disqualified persons.	☐ **Yes**	☑ **No**
c	Do any persons who are disqualified persons, (except individuals who are disqualified persons only because they are foundation managers), have any influence regarding your operations, including your assets or activities? If "Yes," (1) provide the names of these disqualified persons, (2) explain how influence is exerted over your operations (including assets and activities), and (3) explain how control is vested over your operations (including assets and activities) by individuals other than disqualified persons.	☐ **Yes**	☑ **No**

ATTACHMENT A

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part II: *Organizational Structure.*

1 Are you a **corporation**? If "Yes," attach a copy of your articles of incorporation showing **certification of filing** with the appropriate state agency. Include copies of any amendments to your articles and be sure they also show state filing certification.

Please see attached the originally filed articles of incorporation dated September 11, 2015.

BILL GARRETT, Davidson County
Trans:T20150077661 CHARTER
Recvd: 09/11/15 15:50 5 pgs
Fees:7.00 Taxes:0.00
20150911-0092693

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 recieve 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

FILED

OF

NEWCO, INC.

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.

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.

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.

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

ATTACHMENT B

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part II: *Organizational Structure.*

5 Have you adopted **bylaws**? If "Yes," attach a current copy showing date of adoption. If "No," explain how you officers, directors or trustees are selected.

Please see attached Bylaws of Newco, Inc.

Additionally, please see the attached amended and restated bylaws of Newco, Inc. These bylaws will be adopted by Newco after completion of organizational activities and upon commencement of regular operations.

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.

DRAFT FOR DISCUSSION PURPOSES
Monday, October 29, 2015

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 sixteen (16) voting directors, two of whom shall be the Executive Chair/President of the Corporation and the Chief Executive Officer of the Corporation, each of whom who 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 sixteen (16) voting directors, one of whom shall be the Chief Executive Officer of the Corporation who shall serve as a voting ex-officio director. The fifteen (15) 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.

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 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 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.** 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.

(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 _____ __, 2015, 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 Master Affiliation Agreement and Plan of Integration by and between Mountain States Health Alliance and Wellmont Health System dated as of _____ __, 2015 (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.

ATTACHMENT C

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part III: *Required Provisions In Organizing Documents*

Item 1. The location of the purpose clause of the Applicant is found in Article VIII of the Articles of Incorporation of Applicant. See Attachment A.

Part 2.a. The location of the dissolution clause of the Applicant is found in Article XI of the Articles of Incorporation of Applicant. See Attachment A.

ATTACHMENT D

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part IV: *Narrative Description of Activities.*

a. Introduction. Newco, Inc. ("Applicant"), is or will become the sole member of Mountain States Health Alliance, Inc. (the "MSHA") and Wellmont Health System ("Wellmont"), and a supporting organization for MSHA and Wellmont.

b. Identity of Parties.

(i) MSHA. MSHA is a public benefit corporation and the parent company of a large multi-state nonprofit, tax exempt health care delivery system which operates hospitals and health care facilities in Tennessee and Virginia. MSHA was formed in 1945. MSHA is exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code ("Code") pursuant to a determination letter from the Internal Revenue Service, and is a public charity by virtue of its hospital operations.

(ii) Wellmont. Wellmont is a public benefit corporation organized for the benefit of, to perform the functions of, or to carry out the purposes of its health care facilities and its supported organizations, including the arranging for the delivery of health care services through six community acute care hospitals in Tennessee and Virginia, and the provision of related medical outpatient services. Wellmont is exempt from federal income tax under Section 501(c)(3) of the Code pursuant to a determination letter from the Internal Revenue Service, and is a public charity by virtue of its hospital operations.

(iii) Diagram. Corporate organizational charts for MSHA and Wellmont are attached.

c. Purpose (Charitable Purpose). Applicant's formation was a response to concerns of MSHA and Wellmont regarding medical and acute care hospital services in Tennessee and Virginia. Wellmont and MSHA share a common and unifying charitable mission to provide high quality affordable health care and health care-related services; to expand access to health care services; and to promote and improve the health care status of the communities

they serve. Wellmont and MSHA have concluded that it is in the best interests of the residents of the respective communities that they combine their organizations by establishing a single parent company (the Applicant) that oversees all of the assets and operations of the previously separate operations and all of their respective affiliates for the purpose of enhancing the provision of high quality and cost effective health care that such a unified structure will facilitate, and for the purpose of positioning the combined systems to adapt effectively to the changes taking place locally and nationally in the health care delivery and financing systems. In furtherance of those goals, MSHA and Wellmont contemplates entering into a Master Affiliation Agreement and Plan of Integration to establish the structure and operational goals and requirements of their integration. A copy of the draft Master Affiliation Agreement and Plan of Integration is attached.

The health care system operated by Applicant, MSHA, Wellmont and their affiliates 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 health care 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 health care 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 health care 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 health care advancement

Applicant will operate, and cause MSHA and Wellmont to operate, in accordance with the "community benefit standards" as they apply to Code Section 501(c)(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 (subject to certain exclusive physician service arrangements in connection with the provision of hospital-based specialty medical services

approved by the governing body of Applicant from time to time), (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.

MSHA and Wellmont are exempt from taxation pursuant to Code Section 501(c)(3) and promote community health, benefit the community, and fulfill a community need in furtherance of charitable purposes and missions resulting in the expansion of the availability and accessibility of hospital services and physician medical services efficiently delivered to residents of Tennessee and Virginia, including the poor and indigent.

The Applicant will ensure the availability of hospital services and medical care in the most cost-effective and patient-friendly setting in which such services can be rendered in Tennessee and Virginia and the surrounding areas. The Applicant's affiliation with MSHA and Wellmont will provide cost-efficient, higher quality patient care for patients residing in Tennessee and Virginia.

Article VIII of the Articles of Incorporation of the Applicant (the "Articles") specifically set forth the purpose of the Applicant as a supporting organization 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 health care 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.

Article IX of the Articles also (1) prohibits private inurement; and (2) prohibits any action that would cause the Applicant to fail to qualify as a supporting organization.

Applicant's purposes are to promote high-quality, affordable health care services, to improve access to health care, and to promote and improve the health care status of the communities it serves. These purposes will be achieved through its ownership and management of MSHA and Wellmont, which will in turn provide acute care hospital and professional medical services, and are in support and in furtherance of MSHA's and Wellmont's mission to promote high-quality, affordable health care services for a broad cross section of the community, and constitutes an activity that MSHA and Wellmont would otherwise conduct or support if it was not undertaken by Applicant.

The competitive nature of the health care field now necessitates that many of the functions of a large health care system be performed by supporting organizations, such as Applicant, as a part of a reorganized health system. The activities and operations of the Applicant are so organized in order (a) to enhance MSHA's and Wellmont's capability to expand facilities, improve access to health care, and improve efficiencies to allow high-quality, affordable health care services to the communities they serve, and (b) to develop and expand new health-related services for the community.

d. Activity. The Applicant, through its affiliates, will provide medical care and medical services resulting in the promotion of health care through various hospitals, minor medical centers and outpatient facilities in Tennessee and Virginia. The MSHA System is comprised of thirteen hospitals and Wellmont is comprised of six hospitals.

Applicant will serve as a parent company for MSHA and Wellmont. Applicant will directly employ the four officers identified in Part V, Line 1a, each of whom is currently an executive officer of either MSHA or Wellmont. Applicant will provide general management services and oversight for MSHA and Wellmont, including, without limitation, strategic planning, budgeting, financial management, accounting, investment management, risk management, legal, information technology, public relations, government relations, compliance, and internal audit. These activities will be funded by fees paid to Applicant by MSHA and Wellmont pursuant to administrative services agreements with those entities, as further described in Part V, Line 9.

Master Affiliation Agreement

and

Plan of Integration

By and Between

Wellmont Health System

and

Mountain States Health Alliance

Dated as of December __, 2015

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THIS MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "Agreement") is dated as of December __, 2015, 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, Wellmont is a Tennessee public benefit corporation that serves as the parent entity of a health care delivery system which operates hospitals and health care facilities in Tennessee and Virginia; and

WHEREAS, MSHA is a Tennessee public benefit corporation that serves as the parent entity of a health care delivery system which operates hospitals and health care facilities in Tennessee and Virginia; and

WHEREAS, the Parties share a common and unifying charitable mission to provide high quality affordable health care and health care-related services; to expand access to health care services; and to promote and improve the health care status of the communities they serve; and

WHEREAS, Wellmont and MSHA have concluded that it is in the best interests of the residents of the respective communities that they merge their organizations by establishing a single parent company with a self-perpetuating board of directors that oversees all of the assets and operations of the previously separate Parties and all of their respective Affiliates (identified on Exhibit A hereto) on the terms and conditions set forth herein (the "Affiliation") for the purpose of enhancing the provision of high quality and cost effective health care that such a unified structure will facilitate, and for the purpose of positioning the combined systems to adapt effectively to the changes taking place locally and nationally in the health care delivery and financing systems; and

WHEREAS, Wellmont and MSHA reflected these understandings in a nonbinding Term Sheet executed on April 2, 2015; and

WHEREAS, the United States Supreme Court has determined that immunity (known as State action immunity) from federal anti-trust law is available to non-State actors when: (1) such non-State actors carry on their activity pursuant to a clearly articulated policy of the involved State(s) to displace competition with State regulation of the activity to be carried on by non-State actors; and (2) such regulation displacing competition is actively supervised by the involved State(s); and

WHEREAS, both the State of Tennessee and the Commonwealth of Virginia have set out by statute a clear policy permitting, in certain circumstances, the displacement of competition with regulation by the State in the merger of hospital and other healthcare organizations, and both the State of Tennessee and the Commonwealth of Virginia have articulated by statute its intent to actively oversee and supervise any such merger it approves; and

WHEREAS, it is the intent of Wellmont and MSHA to seek approval of their merger, as detailed in this Agreement, pursuant to the statutory schemes of the State of Tennessee and the Commonwealth of Virginia, which would permit the displacement of competition that otherwise exists between Wellmont and MSHA with regulation by both the State of Tennessee and the Commonwealth of Virginia, and it is further the parties' intent to submit the regulation of their merger to the active and continuing oversight of both the State of Tennessee and the Commonwealth of Virginia, all in order to secure State action immunity from federal anti-trust laws to the fullest extent permitted and required; and

WHEREAS, this Agreement is intended to memorialize the actions that each of Wellmont and MSHA must take in order to effect the Affiliation.

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 Shared Vision and Guiding Principles.

Section 1.01 Shared Vision and Guiding Principles. Wellmont and MSHA hereby adopt the statements of Shared Vision and Guiding Principles attached as Exhibit B to this Agreement.

Section 1.02 Community Benefit.

(a) To carry out the Shared Vision and Guiding Principles, prior to the Effective Date Wellmont and MSHA shall have caused Newco, Inc. ("Parent Company") to be formed as a Tennessee nonprofit public benefit corporation to serve as the parent entity of the integrated health system created by the Wellmont and MSHA Affiliation.

(b) Parent Company will operate in accordance with the "community benefit standards" as they apply to Code Section 501(c)(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 (subject to certain exclusive physician service arrangements in connection with the provision of hospital-based specialty medical services approved by the governing body of Parent Company from time to time), (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.

(c) Parent Company will maintain the Parties' existing or equivalent community benefit and education programs and services in effect as of the Effective Time, subject to (i) changes approved by the Parent Company Board of Directors from time-to-time to reflect changing circumstances of the communities served by the Parent Company health system, and (ii) changes in law, policy or regulation as applicable.

(d) Parent Company will abide by policies and provisions of charity care that are no less generous than the policies of the Parties in effect as of the Effective Time, subject to changes in law, policy or regulation as applicable. Notwithstanding Parent Company's commitment to maintain and abide by charity care policies as generous as past policies, nothing herein guaranties any particular level of furnished charity care.

Article II System Structure.

Section 2.01 Actions and Amendments to Organize Parent Company.

(a) Parent Company Formation and Interim Governance. The articles of incorporation (the "Interim Parent Company Articles") and bylaws (the "Interim Parent Company Bylaws") of Parent Company are set forth in Exhibit C-l. The individuals whose names are listed as directors on Exhibit C-2 have been appointed by the Parties pursuant to the Parent Company Bylaws to serve as the directors of Parent Company until the Effective Time (the "Interim Directors"). The individuals whose names are listed as officers on Exhibit C-2 have been appointed by the Interim Directors pursuant to the Parent Company Bylaws to serve as the officers of Parent Company until the Effective Time (the "Interim Officers"). The Interim Directors and Interim Officers shall only take such actions as the Parties direct to complete the organization of Parent Company or to effect the transactions contemplated by this Agreement.

(b) Form 1023 Application. The Interim Directors and Interim Officers shall cause Parent Company to file an Application for Recognition of Exemption Under Code Section 501(c)(3) on Form 1023, and to take such actions and to execute, deliver and file such additional documents and information as may be reasonably necessary to obtain recognition of Parent Company as an organization exempt from taxation under the Code.

(c) Amended Parent Company Articles and Bylaws. On the Effective Date, the Interim Directors shall cause the Parent Company Articles to be amended and restated in the form set forth in Exhibit C-3 (the "Amended Parent Company Articles"), and the Parent Company Bylaws to be amended and restated in the form set forth in Exhibit C-4 (the "Amended Parent Company Bylaws").

(d) Board of Directors of Parent Company.

(i) On the Effective Date the Parties shall cause the individuals who are selected pursuant to the principles described in subsection (ii) below to be elected the directors of Parent Company as of the Effective Time in accordance with the Amended Parent Company Bylaws (the "Initial Directors"). The Initial Directors shall serve until the earlier of their resignation or removal or until their successors are duly elected and qualified in accordance with the Amended Parent Company Bylaws. Simultaneously with such election, the Interim Directors shall submit their resignations, which shall take effect at the Effective Time.

(ii) The directors of Parent Company shall be selected on the following principles. Wellmont and MSHA will each appoint six (6) members to serve on the Board of Directors of Parent Company. Wellmont and MSHA will jointly select two (2) members of the Board of Directors of Parent Company, who shall not be incumbent members of the board of directors of either Wellmont or MSHA. At least two of the persons appointed by each of Wellmont and MSHA shall be licensed physicians who are members of the medical staff of one or more hospitals affiliated with Parent Company; provided, however, that at no time will the number of Interested Persons on the Board of Directors who have voting rights be more than a minority of the total number of directors who have voting rights, and provided further that the total number of voting Directors shall not exceed sixteen (16). The Executive Chairman/President of Parent Company will serve on the Board of Directors of Parent Company as an ex-officio voting member. The initial Chief Executive Officer of Parent Company will serve on the Board of Directors of Parent Company as an ex-officio voting member for a term of two years after the Effective Time. At the conclusion of the initial Chief Executive Officer's two-year term, the Chief Executive Officer will rotate off the Board of Directors of the Parent Company and a replacement director shall be elected in accordance with the terms of the Amended Parent Company Bylaws. The President of East Tennessee State University will serve on the Amended Parent Company Board of Directors as an ex officio nonvoting member.

(e) Parent Company Board Committees. Subject to the rights of the Board pursuant to the Amended Parent Company Bylaws, the Parent Company Board of Directors will have the following standing committees: Executive; Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Community Benefit; Workforce; and Governance / Nominating. By the Effective Date, the Parties shall mutually determine the individuals who shall serve as the initial members of such committees and the Parent Company Board shall appoint such individuals to such committee memberships.

(f) Board Officers. Effective as of the Effective Time, the Board Officers of Parent Company shall consist of an Executive Chairman/President, a Vice Chairman/Lead Independent Director, a Chief Executive Officer, a Secretary and a Treasurer and shall be the individuals whose names are listed on Exhibit D-1, who shall serve in such office until the earlier of their resignation or removal or until their successors are duly elected or appointed and qualified in accordance with the Amended Parent Company Bylaws.

(g) Initial Management Team of Parent Company. The initial corporate officers of Parent Company (the "Initial Management Team") shall include the Executive Chairman/President, Chief Executive Officer, Chief Operating Officer and Chief Financial Officer. On the Effective Date, the Initial Directors shall cause the individuals whose names and corporate offices are listed on Exhibit D-1 to be elected to such offices.

Simultaneously with such election, the Interim Officers shall submit their resignations, which shall take effect at the Effective Time.

(i) The position description for the Executive Chairman/President shall be substantially similar to the position description attached hereto as Exhibit D-2 and ensure the position is the most senior officer of Parent Company. The employment contract for the Executive Chairman/President in the form and containing the terms approved by the Joint Board Task Force, the MSHA Board and the Wellmont Board prior to the date of this Agreement will be executed by the Vice Chair/Lead Independent director on behalf of the Parent Company and by the Executive Chairman/President on the Effective Date. The Executive Chairman/President shall report to the Board of Parent Company which shall be responsible for conducting the evaluation of the Executive Chairman/President. In the event of separation between the Parent Company and the Executive Chairman/President prior to the second anniversary of the Effective Time, the position shall be filled as described in the Amended Parent Company Bylaws.

(ii) The position description for the Chief Executive Officer shall be substantially similar to the position description attached hereto as Exhibit D-3. The employment contract for the Chief Executive Officer in the form and containing the terms negotiated by the Executive Chairman/President and ratified by the Joint Board Task Force, the MSHA Board and the Wellmont Board prior to the date of this Agreement will be executed by the Executive Chairman/President on behalf of Parent Company and by the Chief Executive Officer on the Effective Date. The Chief Executive Officer shall report to the Executive Chairman/President, who shall be responsible for conducting the evaluation of the Chief Executive Officer.

(iii) The position descriptions for Chief Operating Officer and the Chief Financial Officer of the Parent Company, as developed by the Chief Executive Officer and approved by the Executive Chairman/President are attached hereto as Exhibit D-4.

(iv) On or soon after the Effective Date, the Executive Chairman/President will submit to the Parent Company Board for its approval, a proposed policy for delegating Board authority to corporate officers for managing and conducting the business of the Parent Company.

(h) Governance. The Parent Company shall be governed in accordance with the terms and practices set forth in the Amended Parent Company Bylaws as they are modified from time to time in accordance with the vote and process set forth therein.

Section 2.02 Membership Changes and Amendments to Governing Documents of MSHA and Wellmont.

(a) MSHA Membership Changes and Amendments. On the Effective Date, MSHA shall cause Parent Company to become its sole member by amending and restating its Articles of Incorporation effective as of the Effective Time in a form mutually agreed upon by the Parties (the "Amended MSHA Articles") and filing the Amended MSHA Articles with the Tennessee Secretary of State. On the Effective Date, MSHA shall cause its Bylaws to be amended and restated in a form mutually agreed upon by the Parties (the "Amended MSHA Bylaws") effective as of the Effective Time.

(b) Wellmont Membership Changes and Amendments. On the Effective Date, Wellmont shall cause Parent Company to become its sole member by amending and restating its Articles of Incorporation effective as of the Effective Time in a form mutually agreed upon by the Parties (the "Amended Wellmont Articles") and filing the Amended Wellmont Articles with the Tennessee Secretary of State. On the Effective Date, Wellmont shall cause its Bylaws to be amended and restated in a form mutually agreed upon by the Parties effective as of the Effective Time (the "Amended Wellmont Bylaws").

(c) MSHA and Wellmont Boards of Directors. On the Effective Date, the individuals selected by the Parties to be the initial directors of the Parent Company shall also be elected the directors of MSHA and Wellmont as of the Effective Time.

(d) Affiliate Membership Changes and Amendments. Prior to the Effective Date, the Parties will agree upon the modifications and amendments necessary to conform the Articles of Organization, Charters, Bylaws and Operating Agreements of all the Wellmont Subsidiaries and all the MSHA Subsidiaries to establish an initial equal role for Wellmont and MSHA in governance of each of them during the Integration Period and to make such other changes as the Parties agree are necessary or appropriate to establish and maintain the direct or indirect authority of the Newco Board of Directors over all such Subsidiaries.

Section 2.03 Effective Time. The Affiliation shall be effective as of the day and hour specified in Section 5.01 of this Agreement (the "Effective Time").

Section 2.04 Debts and Liabilities. At the Effective Time subject to the approval of the Parent Company Board of Directors, Parent Company shall guarantee such tax exempt and taxable bond indebtedness of Wellmont and MSHA as is necessary to result in an increase in the credit rating assigned by the three principal credit rating agencies to the aggregate outstanding bond indebtedness of all entities within the integrated healthcare system overseen by the Parent Company.

Section 2.05 Name of the Integrated Health System. Prior to the Effective Date, the Parties shall agree upon the name of the integrated health system created by the Wellmont and MSHA Affiliation, which name shall be reflected in the Charter and Bylaws of Parent Company that will become effective at the Effective Time.

Section 2.06 Indemnification, Exculpation and Insurance.

(a) The Amended Parent Company Bylaws, Amended MSHA Bylaws and Amended Wellmont Bylaws shall include the fullest indemnification and exculpation of the current and former directors, officers, and board committee members of each organization or who served at the request of any of them as a director or officer of another Person (the “Indemnified Parties”) that is allowable under Tennessee law both with respect to service prior to the Effective Time and with respect to service following the Effective Time. Such Bylaws shall also provide for advancement of the costs of defense upon a finding by the Parent Company Board of Directors that the individual seeking advancement of such costs met the standard of conduct for indemnification and upon the individual providing a written undertaking to repay the advanced amounts in the event that the Parent Company Board of Directors ultimately determines that the individual was not entitled to indemnification under applicable Tennessee law.

(b) For a period of six years from and after the Effective Time, Parent Company shall either cause to be maintained in effect the current policies of directors' and officers' liability insurance and fiduciary liability insurance maintained by MSHA and Wellmont or provide substitute policies for the Company and its current and former directors and officers who are currently covered by the directors' and officers' and fiduciary liability insurance coverage currently maintained by the Company in either case, of not less than the existing coverage and having other terms not less favorable to the insured persons than the directors' and officers' liability insurance and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont with respect to claims arising from facts or events that occurred on or before the Effective Time (with insurance carriers having at least an "A" rating by A.M. Best with respect to directors' and officers' liability insurance and fiduciary liability insurance), except that in no event shall Parent Company be required to pay with respect to such insurance policies in respect of any one policy year more than 250% of the aggregate annual premium most recently collectively paid by MSHA and Wellmont prior to the date of this Agreement (the "Maximum Amount"), and if Parent Company is unable to obtain the insurance required by this Section 2.06(b) it shall obtain as much comparable insurance as possible for the years within such six-year period for an annual premium equal to the Maximum Amount, in respect of each policy year within such period. In lieu of such insurance, prior to the Effective Date Parent Company may, at its option, purchase a "tail" directors' and officers' liability insurance policy and fiduciary liability insurance policy for the MSHA, Wellmont and their current and former directors and officers who are currently covered by the directors' and officers' and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont, such tail to provide coverage in an amount not less than the existing coverage and to have other terms not less favorable to the insured persons than the directors' and officers' liability insurance and fiduciary liability insurance coverage currently maintained by MSHA and Wellmont with respect to claims arising from facts or events that occurred on or before the Effective Time; provided that in no event shall the cost of any such tail policy in respect of any one policy year exceed the Maximum Amount. In the event Parent Company purchases such tail coverage, Parent Company shall cease to have any obligations under the first sentence of this

Section 2.06(b). Parent Company shall maintain such policies in full force and effect, and continue to honor the obligations thereunder.

(c) In the event that Parent Company, MSHA or Wellmont or any of their successors or assigns (i) consolidates with or merges into any other Person and is not the continuing or surviving corporation or entity of such consolidation or merger or (ii) transfers or conveys all or substantially all of its properties and assets to any Person, then, and in each such case, Parent Company, MSHA or Wellmont, as applicable, shall cause proper provision to be made so that the successors and assigns of Parent Company, MSHA or Wellmont, as applicable, assume the obligations set forth in this Section 2.06.

(d) For a period of six years from and after the Effective Time, each of Parent Company, MSHA and Wellmont shall maintain in effect the provisions in its articles of incorporation and bylaws to the extent they provide for indemnification, advancement and reimbursement of expenses and exculpation of each Indemnified Party as applicable, with respect to facts or circumstances occurring at or prior to the Effective Time, on the same basis as set forth in its articles of incorporation and bylaws in effect as of the Effective Time, which provisions shall not be amended during such time except as required by applicable law or except to make changes permitted by applicable law that would enlarge the scope of the Indemnified Parties' indemnification rights thereunder.

(e) The provisions of this Section 2.06 shall survive the consummation of the transactions contemplated by this Agreement, (ii) are intended to be for the benefit of, and will be enforceable by, each of the Indemnified Parties, his or her heirs and his or her representatives, and (iii) are in addition to, and not in substitution for, any other rights to indemnification or contribution that any such Person may have by contract or otherwise.

Article III Representations and Warranties of Wellmont.

Subject to the limitations and qualifications set forth in this Agreement, Wellmont represents and warrants to MSHA the matters set forth below. Statements by Wellmont with respect to the Wellmont Subsidiaries (as defined in Section 3.03) refer to all of its subsidiaries.

Section 3.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by MSHA, this Agreement is a legal, valid, and binding obligation of Wellmont and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential memorandum delivered by Wellmont legal counsel to MSHA legal counsel prior to the date of this Agreement (the "Wellmont Counsel Memorandum"), the execution, delivery and performance of this Agreement by Wellmont are within its corporate powers. Except as set forth in the Wellmont Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by Wellmont and the consummation of the transactions contemplated hereby by Wellmont will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other

business association or public authority; (ii) violate any provisions of law applicable to Wellmont or to any of the Wellmont Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of Wellmont or any of the Wellmont Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which Wellmont or any of the Wellmont Subsidiaries is a party or by which Wellmont or any of the Wellmont Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of Wellmont or any of the Wellmont Subsidiaries or increase the rate of interest payable by Wellmont or by any of the Wellmont Subsidiaries with respect to any indebtedness.

Section 3.02 Organization; Power; Good Standing. Wellmont is a nonprofit corporation duly organized and validly existing under the laws of the State of Tennessee and has all requisite corporate power and authority to own, lease, and operate its properties, to carry on its business as now being conducted, and to enter into this Agreement and perform its obligations hereunder. True and correct copies of the Articles of Incorporation and Bylaws or Articles of Organization and Operating Agreements, as applicable, of each of Wellmont and the Wellmont Subsidiaries have been provided to MSHA. Neither the character of the properties owned or leased by Wellmont nor the nature of the business conducted by Wellmont requires the licensing or qualification of Wellmont as a corporation in any jurisdiction other than the State of Tennessee and the Commonwealth of Virginia.

Section 3.03 Wellmont Subsidiaries. Other than as disclosed in the Wellmont Counsel Memorandum, Wellmont does not directly or indirectly own any interest in any other corporation, partnership, joint venture, or other business association or entity, foreign or domestic. Such corporations, partnerships, joint ventures, or other business entities set forth in the Wellmont Counsel Memorandum of which it owns, directly or indirectly, more than fifty percent (50%) of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests) are referred to herein each as a "Wellmont Subsidiary" or collectively as the "Wellmont Subsidiaries." Set forth in the Wellmont Counsel Memorandum is an indication of the interest owned by Wellmont in each corporation, partnership, joint venture, or other business association or entity in which Wellmont owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests). With respect to the Wellmont Subsidiaries, Wellmont represents and warrants the following:

(a) Each Wellmont Subsidiary that is a corporation is a corporation duly organized, validly existing, and in good standing under the laws of the jurisdiction of its incorporation. Each Wellmont Subsidiary that is a limited liability company is duly formed and validly existing under the laws of its jurisdiction of formation.

(b) Each Wellmont Subsidiary has the corporate power, or power under the Tennessee Limited Liability Company Act or the Virginia Limited Liability Company Act, as the case may be, and its internal governing documents, as applicable, and authority to own, lease, and operate its properties and to carry on its business as presently conducted or presently proposed to be conducted.

(c) Each Wellmont Subsidiary is duly qualified to do business as a foreign corporation or limited liability company, as the case may be, and is in good standing, in each jurisdiction where the character of its properties owned or held under lease or the nature of its activities makes such qualification necessary.

(d) All of the outstanding shares of capital stock or other equity interests of the Wellmont Subsidiaries that are for-profit entities and all membership interests in non-profit entities are, in each case, validly issued, fully paid, and non-assessable.

(e) All of the outstanding shares of capital stock of, or other ownership or membership interests in, each of the Wellmont Subsidiaries owned by Wellmont or by any of the Wellmont Subsidiaries are so owned free and clear of any liens, claims, charges, or encumbrances. There are no outstanding options, warrants, subscriptions, calls, rights, convertible securities, or other agreements or commitments obligating Wellmont or any of the Wellmont Subsidiaries to issue, transfer, or sell any securities of any Wellmont Subsidiary.

(f) There are no voting trusts, standstill, shareholder, partnership, operating, or other agreements or understandings to which Wellmont or a Wellmont Subsidiary is a party or is bound with respect to the voting of the capital stock or other ownership interest in any Wellmont Subsidiary.

Section 3.04 Financial Statements. Wellmont has delivered to MSHA, or will deliver to MSHA within five (5) days of becoming available, copies of (i) its audited consolidated financial statements for the years ended June 30, 2013 and June 30, 2014 and for each year thereafter through the Effective Date, as presented by the auditors regularly retained by Wellmont, together with any management letters issued by the auditors in connection with the foregoing and a written copy of all material presented to the Audit Committee of the Wellmont Board, and (ii) its unaudited interim consolidated financial reports for the year ended June 30, 2015 and for the for the two months ended August 31, 2015 and each month thereafter through the Effective Date. Such financial statements, together with the notes thereto, and such interim unaudited consolidated financial reports (collectively, the "Financial Statements"), are in accordance with the books and records of Wellmont; and except as otherwise set forth in the Wellmont Counsel Memorandum, fairly present in all material respects the financial position of Wellmont and the results of operations and cash flows for the years then ended or other periods indicated in conformity with generally accepted accounting principles ("GAAP") applied on a consistent basis throughout such periods, except to the extent that the interim unaudited consolidated financial reports contain no notes and are subject to year-end audit adjustments that are not, individually or in the aggregate, material and, except as noted in such statements, consistent with

prior periods. The most recent balance sheet of Wellmont included in its Financial Statements is referred to herein as its "Balance Sheet." The "Balance Sheet Date" shall mean June 30, 2015.

Section 3.05 Absence of Undisclosed Liabilities. Other than with respect to matters addressed in Section 3.17, representations concerning which are contained only in Section 3.17, except as expressly disclosed or reserved against on the Balance Sheet or as specifically set forth in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries had, as of the Balance Sheet Date, any debts, liabilities, or obligations of any nature, whether accrued, absolute, contingent, or otherwise, and whether due or to become due, including, but not limited to, guarantees, liabilities, or obligations on account of Taxes (as defined in Section 3.08 below), other governmental charges, duties, penalties, interest, fines, or obligations to refund, required in accordance with GAAP to be disclosed on the Balance Sheet.

Section 3.06 Absence of Certain Changes. Except as set forth in the Wellmont Counsel Memorandum, as disclosed to MSHA prior to the date hereof through the process established in Section 5.04 for sharing Competitive Sensitive Information (the "Black Box Process"), or as permitted by this Agreement, since the Balance Sheet Date, Wellmont has suffered no Material Adverse Effect.

Section 3.07 Contracts. The Wellmont Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which Wellmont or any of the Wellmont Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by Wellmont or any of the Wellmont Subsidiaries thereto of more than $250,000 on an annual basis; or (ii) to the Knowledge of Wellmont, are with, or relate to, any physician; or (iii) to the Knowledge of Wellmont, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Internal Revenue Code of 1986, as amended (the "Code")(each a "Wellmont Material Contract"). "Knowledge of Wellmont" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of Wellmont. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization's governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization's affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization's capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from activities of

the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has entered into any Wellmont Material Contract. All Wellmont Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. Wellmont and the Wellmont Subsidiaries and, to the Knowledge of Wellmont, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each Wellmont Material Contract. Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries nor, to the Knowledge of Wellmont, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the Wellmont Counsel Memorandum, none of the rights of Wellmont or any of the Wellmont Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the Wellmont Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to MSHA.

Section 3.08 Tax Matters. For purposes of this Section:

(a) "Tax" or "Taxes" means any federal, state, or local income (including unrelated business income), gross receipts, license, payroll, employment, excise, severance, stamp, occupation, premium, environmental (including taxes under Code Section 59A), capital stock, franchise, profits, withholding, social security (or similar), unemployment, disability, real property, personal property, sales, use, transfer, registration, estimated, or other tax of any kind whatsoever, including any interest, penalty, or addition thereto, whether disputed or not.

(b) "Tax Return" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

(c) Wellmont and the Wellmont Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file on or before the Effective Date. All such Tax Returns are correct and complete in all material

respects. All material Taxes due and owing by Wellmont and the Wellmont Subsidiaries have been paid or reserved against in such party's Financial Statements. Neither Wellmont nor the Wellmont Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth in the Wellmont Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where Wellmont or the Wellmont Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

(d) Wellmont and the Wellmont Subsidiaries have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, stockholder, or other third party.

(e) There is no material dispute or claim concerning any Tax liability of Wellmont or any entity listed in Schedule 3.03 of the Wellmont Counsel Memorandum either: (i) claimed or raised by any governmental authority in writing and brought to the attention of any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries; or (ii) as to which any of the directors, officers, or employees responsible for Tax matters of Wellmont and the Wellmont Subsidiaries has knowledge based upon personal contact with any agent of such governmental authority. Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries is the subject of an audit or examination by any governmental authority with respect to its potential liability for Taxes.

(f) Neither Wellmont nor the Wellmont Subsidiaries has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency.

(g) Other than as disclosed in the Wellmont Counsel Memorandum, Wellmont and each of the Wellmont Subsidiaries is not a party to and have no continuing obligations under any Tax allocation or sharing agreement. Wellmont and each of the Wellmont Subsidiaries: (i) have not been members of an affiliated group (within the meaning of Code § 1504(a)) filing a consolidated federal income Tax Return, and (ii) have no liability for the Taxes of any entity or unincorporated organization (other than Wellmont and the Wellmont Subsidiaries) under Treasury Regulation § 1.1502-6 (or any similar provision of state, local, or foreign law), as a transferee or successor, by contract or otherwise.

(h) The unpaid Taxes of Wellmont and the Wellmont Subsidiaries: (i) did not, as of the Balance Sheet Date, exceed by any material amount the reserve for Tax liability (excluding any reserve for deferred Taxes established to reflect timing differences between book and Tax income) set forth on the face of the Balance Sheet as of the Balance Sheet Date (rather than in any notes thereto), and (ii) will not exceed by any material amount that reserve as adjusted for the passage of time through the Effective Date in accordance with the past custom and practice of Wellmont and the Wellmont Subsidiaries in filing its Tax Returns.

(i) Wellmont and the Wellmont Subsidiaries that claim to be tax-exempt under Code Section 501(c)(3) (for purposes of this Section 3.08.(i) only, the "Tax-Exempt Wellmont Subsidiaries") have, by reason of letters from the Internal Revenue Service, been determined by the Internal Revenue Service to be exempt from federal income taxation under Code Section 501(c)(3) and not to be private foundations under Code Section 509(a). Wellmont has no Knowledge of any facts or circumstances which would cause the Internal Revenue Service to revoke such determinations or to conclude that Wellmont or the Tax Exempt Wellmont Subsidiaries are "private foundations" as defined in Code Section 509(a). Wellmont has no Knowledge of any facts or circumstances indicating that any part of the net earnings of Wellmont or the Tax Exempt Wellmont Subsidiaries inures to the benefit of any private member or individual, within the meaning of Code Section 501(c)(3). Neither Wellmont nor the Tax-Exempt Wellmont Subsidiaries has taken or permitted any action that would subject Wellmont or any Tax-Exempt Wellmont Subsidiary to penalty excise taxes (also known as "Intermediate Sanctions") under the Taxpayer Bill of Rights 2 (Pub. L. No. 104-168, 110 Stat. 1452).

Section 3.09 Title to Properties. Wellmont and the Wellmont Subsidiaries have good and marketable title to, or a valid leasehold interest in, all their real and personal property and other assets, tangible and intangible, subject to no security interest, pledge, lien, encumbrance, claim, charge, or other restrictions other than; (a) those incurred in the ordinary course of Wellmont's business, including those related to debt obligations of Wellmont reflected in the Financial Statements, and (b) "Permitted Liens." For the purposes of this Agreement, "Permitted Liens" shall mean: (i) easements that do not materially adversely affect the full use and enjoyment of the Owned Real Property (as defined in Section 3.13 below) or Leased Real Property (as defined in Section 3.13 below) for the purposes for which it is currently used or materially detract from its value; (ii) imperfections of title and encumbrances, if any, individually or in the aggregate, which are not material, do not materially detract from the marketability or value of the properties subject thereto, and do not materially impair the operations of the owner thereto; (iii) liens for taxes not yet due and payable; and (iv) liens incurred in the ordinary course of business in connection with governmental insurance or benefits or to secure performance of leases and contracts (other than for borrowed money) which liens do not, individually or in the aggregate, materially and adversely affect the full use and enjoyment of the properties to which they are attached.

Section 3.10 Litigation. The Wellmont Counsel Memorandum contains a true and correct listing of all material litigation, administrative, arbitration, and other proceedings in which Wellmont or any of the Wellmont Subsidiaries is currently involved, and all court decrees or administrative orders to which Wellmont or any of the Wellmont Subsidiaries is subject. Other than as shown in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, there is no claim, action, suit, proceeding (legal, administrative, or otherwise), investigation, or inquiry (by an administrative agency, governmental body, or otherwise) pending as to which Wellmont has been served process or otherwise notified or, to the Knowledge of Wellmont, threatened in writing by or against, Wellmont or any of the Wellmont Subsidiaries, their properties or assets, or the transactions contemplated hereby, at law or in equity, or before or by any federal, state, municipal, or other

governmental department, commission, board, agency, instrumentality, or authority, domestic or foreign, the result of which could reasonably be expected to have a Material Adverse Effect.

Section 3.11 Compliance with Law. Other than with respect to matters addressed in Section 3.17, representations concerning which are contained only in Section 3.17, and except as set forth in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, Wellmont and the Wellmont Subsidiaries are in compliance in all material respects with all applicable laws, rules, regulations, and licensing requirements of all federal, state, local, and foreign authorities.

Section 3.12 Permits and Licenses. Wellmont and the Wellmont Subsidiaries maintain in full force and effect all permits, licenses, orders, and approvals necessary for them to carry on their respective businesses as presently conducted other than such permits, licenses, orders, and approvals the absence of which, individually or in the aggregate, has not had and would not reasonably be expected to have a Material Adverse Effect. All fees and charges incident to such permits, licenses, orders, and approvals have been fully paid and are current, and no suspension or cancellation of any such permit, license, order, or approval has been threatened or could result by reason of the transactions contemplated by this Agreement. Neither Wellmont nor any of the Wellmont Subsidiaries have received any notice from any Governmental Entity that any Wellmont Facilities are not in substantial compliance with all of the terms, conditions, and provisions of such permits, consents, approvals, or licenses. Wellmont heretofore has made available to MSHA correct and complete copies of all such permits, consents, orders, approvals, and licenses. A list of all permits, licenses, orders, and approvals held by Wellmont and the Wellmont Subsidiaries is set forth in the Wellmont Counsel Memorandum.

Section 3.13 Real Property.

(a) Owned. Except as set forth in the Wellmont Counsel Memorandum, Wellmont and the Wellmont Subsidiaries have good and marketable title to all real property reflected on their respective balance sheets (collectively, the "Owned Real Property"). Except as set forth in the Wellmont Counsel Memorandum, (i) neither Wellmont nor any Wellmont Subsidiary has agreed, orally or in writing, or is otherwise obligated, to sell, lease, encumber, or otherwise dispose of any of the Owned Real Property; and (ii) other than tenant leases entered into in the ordinary course of operations, no person or entity has any leasehold interest in, and no person or entity (other than Wellmont or a Wellmont Subsidiary) has any right to use, operate, or occupy any of the Owned Real Property.

(b) Leased. With respect to all real property leased by Wellmont or the Wellmont Subsidiaries which (i) involve the expenditure by Wellmont or any of the Wellmont Subsidiaries of more than $250,000 on an annual basis or (ii) to the Knowledge of Wellmont, are with, or relate to, any physician (collectively, the "Leased Real Property") and all leases relating thereto (collectively, the "Real Property Leases"), Wellmont represents and warrants that except as set forth in Wellmont Counsel Memorandum, (i) each Real Property Lease is valid, binding, and enforceable in

accordance with its terms and is in full force and effect, and there are no offsets or __defenses by either landlord or tenant thereunder; (ii) there are no existing breaches of or defaults under, and no events or circumstances have occurred which, with or without notice or lapse of time, or both, would constitute a breach of or a default under, any of the Real Property Leases; and (iii) consummation of the Affiliation will not constitute or result in a breach or default under any Real Property Lease. A list of all Real Property Leases of Wellmont and the Wellmont Subsidiaries is set forth in the Wellmont Counsel Memorandum.

(c) Improvements. The Owned Real Property and the Leased Real Property are zoned for the various purposes for which the buildings and other improvements located thereon (the "Improvements") are presently being used, except in the case of permitted nonconforming uses. All of the Improvements and all uses thereof are in material compliance with all applicable zoning and land use laws, ordinances, and regulations. No part of any of the Improvements encroach on any real property not included in the Owned Real Property or the Leased Real Property in such a way that the remediation of the encroachment would prevent Wellmont's continued use of the Improvements to such an extent as to materially affect such Party's operations.

Section 3.14 Environmental Protection. Except as set forth in the Wellmont Counsel Memorandum, and to the Knowledge of Wellmont:

(a) Wellmont and the Wellmont Subsidiaries are in compliance in all material respects with federal, state, and local environmental laws and regulations that are applicable to Wellmont and the Wellmont Subsidiaries and to their respective business operations.

(b) No substances that are defined and regulated by applicable environmental laws and regulations as toxic substances, hazardous wastes, hazardous materials, or hazardous substances (including, without limitation, asbestos, and petroleum and its constituents) (collectively, "Hazardous Substances") have been stored, disposed of, or released in or on the Owned Real Property, the Leased Real Property, the Improvements, or other assets of Wellmont or the Wellmont Subsidiaries in any manner, locations, or amounts that are outside of the ordinary course of business for Wellmont and the Wellmont Subsidiaries, or that violate applicable environmental laws and regulations, or that create material response duties or material cleanup liability for Wellmont or any of the Wellmont Subsidiaries.

(c) Wellmont and the Wellmont Subsidiaries have received no written notices regarding any potential claims, costs, or liabilities being asserted or to be asserted against Wellmont or the Wellmont Subsidiaries arising from or related to the off-site transport or disposal of Hazardous Substances from the owned Real Property or the Lease Real Property.

Section 3.15 Insurance. Other than as set forth in the Wellmont Counsel Memorandum, Wellmont and the Wellmont Subsidiaries maintain in force valid, binding, and enforceable insurance policies providing adequate coverage for all risks normally insured against by others in the businesses of Wellmont and the Wellmont Subsidiaries. All premiums due thereon have been paid and will be paid through the Effective Date. Neither Wellmont nor any of the Wellmont Subsidiaries has been refused any insurance by any insurance carrier during the past two years. All insurance policies maintained by Wellmont and by the Wellmont Subsidiaries are described in the Wellmont Counsel Memorandum.

Section 3.16 Employees; Benefit Plans.

(a) Except as set forth in the Wellmont Counsel Memorandum, there are no Plans, as defined below, contributed to, maintained, or sponsored by Wellmont or any of the Wellmont Subsidiaries, to which Wellmont or any Wellmont Subsidiary is obligated to contribute or with respect to which it has any current or future obligation or liability, including all Plans contributed to, maintained, or sponsored in the past six years by any current or former member of the controlled group of companies, within the meaning of Sections 414(b), 414(c), 414(m), and 414(o) of the Code, of which Wellmont or any of the Wellmont Subsidiaries is a member. For the purposes of this Agreement, the term "Plans" shall mean: (i) employee benefit plans as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), whether or not funded and whether or not terminated; (ii) employment agreements (exclusive of physician contracts); and (iii) personnel policies or fringe benefit plans, policies, programs, and arrangements, whether or not subject to ERISA, whether or not funded, whether written or unwritten, and whether or not terminated, including without limitation, stock bonus, deferred compensation, pension, severance, bonus, vacation, sabbatical, travel, incentive, and health, disability, and welfare plans.

(b) Except as set forth in the Wellmont Counsel Memorandum, none of the Plans obligates Wellmont or any of the Wellmont Subsidiaries to pay separation, severance, termination, or similar-type benefits solely as a result of any transaction contemplated by this Agreement or solely as a result of a "change in control," as such term is used in Section 280G of the Code and the regulations promulgated thereunder.

(c) Except as set forth in the Wellmont Counsel Memorandum, each Plan and all related trusts, insurance contracts, and funds have been maintained, funded, and administered in compliance with all applicable laws and regulations, including but not limited to ERISA and the Code. Each Plan that is intended to be a qualified retirement plan and its related trust, if any, are qualified under Code Section 401(a) and Code Section 501(a) and have been determined by the Internal Revenue Service to qualify, and nothing has occurred since the latest determination of their qualified status by the Internal Revenue Service to cause the loss of such qualification. In addition to the foregoing, each Plan that is intended to be a tax-deferred annuity plan within the meaning of Code Section 403(b), has been administered in accordance with the provisions of that Section. Except as set forth the Wellmont Counsel Memorandum, no Plan that is qualified under

Code Section 401(a) has ever been merged with or accepted transfers from another Plan under Code Section 414(1).

(d) Wellmont has provided to MSHA the latest actuarial valuation report for each Plan that is a defined benefit pension plan and the most recent information on contributions and the fair market value of the assets for each Plan. All financial and employee census data, and all other information provided by Wellmont to the actuaries for each such Plan in order to prepare the latest actuarial report for each such Plan was true, correct and complete in all material respects. With respect to each Plan that is subject to the funding requirements of Section 412 of the Code and Section 302 of ERISA, all contributions required to have been made for all periods ending prior to or as of the Effective Date (including periods from the first day of the then-current plan year to the Effective Date) have been made, and no accumulated funding deficiency (as defined in Code Section 412(a)) has been incurred, without regard to any waiver granted under Code Section 412. With respect to each other Plan, all required payments, premiums, contributions, reimbursements, or adequate accruals for all periods ending prior to or as of the Effective Date have been made within the time due. Except as set forth in the Wellmont Counsel Memorandum, no Plan which is a qualified retirement plan within the meaning of Section 401(a) of the Code ("Qualified Plan") has any material unfunded liabilities.

(e) There have been no prohibited transactions with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. There has been no breach of fiduciary duty (including violations under Part 4 of Title I of ERISA) with respect to any Plan which could result in liability to the Representing Party, any of the Wellmont Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. No action, suit, proceeding, hearing, or investigation relating to any Plan (other than routine claims for benefits) is pending or has been threatened, and neither Wellmont nor any of the Wellmont Subsidiaries, nor any of their respective employees, has knowledge of any fact that would reasonably be expected to form the basis for such action, suit, proceeding, hearing, or investigation. Except as set forth in the Wellmont Counsel Memorandum, no matters are currently pending with respect to any Plan under the Employee Plans Compliance Resolution System maintained by the Internal Revenue Service or any similar program maintained by any other government authority.

(f) Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has ever sponsored, maintained, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any employee pension benefit plan covered by Title IV of ERISA, Section 302 of ERISA, or Section 412 of the Code. Neither Wellmont nor any of the Wellmont Subsidiaries has ever had any obligation to contribute to, participated in, or been subject to any liability under or with respect to any "multiemployer plan" as defined in Section

3(37) of ERISA or any "multiple employer welfare arrangement" as defined in Section 3(40)(A) of ERISA.

(g) Except as disclosed in the Wellmont Counsel Memorandum, neither Wellmont nor any of the Wellmont Subsidiaries has ever sponsored, maintained, administered, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any policy, practice, agreement, or Plan which provides health, life, or other coverage for former directors, officers, or employees (or any spouse or former spouse or other dependent thereof), other than benefits required by COBRA or comparable state-mandated health plan continuation coverage.

(h) Neither Wellmont nor any of the Wellmont Subsidiaries has ever maintained a "voluntary employees' beneficiary association" within the meaning of Section 501(c)(9) of the Code or any other "welfare benefit fund" as defined in Section 419(e) of the Code.

(i) With respect to each Plan that is subject to COBRA and that benefits any current or former employee of Wellmont or any of the Wellmont Subsidiaries, Wellmont or the Wellmont Subsidiaries has complied in all material respects with the continuation coverage requirements of COBRA to the extent such requirements are applicable.

(j) All reports and information relating to each Plan required to be filed with a government authority have been timely filed and are accurate in all material respects, all reports and information relating to each such Plan required to be disclosed or provided to participants or their beneficiaries have been timely disclosed or provided, and there are no restrictions on the right of Wellmont or any of the Wellmont Subsidiaries to terminate or decrease (prospectively) the level of benefits under any Plan after the Effective Date without liability to any participant or beneficiary thereunder.

(k) Except as reflected in the Wellmont Counsel Memorandum, each Plan sponsored by Wellmont or any of the Wellmont Subsidiaries is terminable at the discretion of such entity with no more than 30 days' advance notice and without material cost to such entity. Wellmont and any of the Wellmont Subsidiaries may, without material cost, withdraw their employees, directors, officers, and consultants from any Plan which is not sponsored by such entity. Except as reflected in the Wellmont Counsel Memorandum, no Plan has any provision which could increase or accelerate benefits or any provision which could increase liability to MSHA as a result of the transactions contemplated hereby, alone or together with any other event. Except as reflected in the Wellmont Counsel Memorandum, no Plan imposes withdrawal charges, redemption fees, contingent deferred sales charges, or similar expenses triggered by termination of the plan or cessation of participation or withdrawal of employees thereunder. No officer, trustee, agent, or employee of Wellmont or any of the Wellmont Subsidiaries has made any oral or written representation which is inconsistent with the terms of any Plan which may be binding on such Plan, the Representing Party, or any of the Wellmont Subsidiaries.

(l) Each nonqualified deferred compensation plan within the meaning of Code Section 409A has been administered in compliance in all material respects with the plan terms, to the extent consistent with Code Section 409A and the applicable guidance, as described in IRS Notice 2007-86.

(m) Neither Wellmont nor any of the Wellmont Subsidiaries has any leased employees within the meaning of Code Section 414(n).

Section 3.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

(i) "Governmental Entity" shall mean any government or any agency, bureau, board, directorate, commission, court, department, official, political subdivision, tribunal, or other instrumentality of any government, whether federal, state, or local, domestic or foreign.

(ii) "Person" shall mean an association, a corporation, a limited liability company, an individual, a partnership, a limited liability partnership, a trust, or any other entity or organization, including a Governmental Entity.

(b) All hospitals and other health care providers owned or operated as continuing operations by Wellmont or any Wellmont Subsidiary (each, a "Wellmont Facility," and together, the "Wellmont Facilities") that make claims for payment under Title XVIII of the Social Security Act ("Medicare") and Title XIX of the Social Security Act ("Medicaid") are eligible to receive payment without restriction under Medicare and Medicaid, and each of them is a "provider" or "supplier" with valid and current provider agreements and with one or more provider numbers with the federal Medicare program and the Medicaid program of Tennessee or Virginia (the "Government Programs") through a contractor, a fiscal intermediary, or a carrier, as applicable. Each of the Wellmont Facilities that makes claim for payment under TRICARE programs is a "provider" with valid and current provider agreements and with one or more provider numbers with TRICARE. Each Wellmont Facility is in compliance with the conditions of participation for the Government Programs and TRICARE in all material respects and has received all approvals or qualifications necessary for capital reimbursement of the assets of Wellmont or a Wellmont Subsidiary, except where the failure to be in such compliance or to have such approvals or qualifications would not individually or in the aggregate have a Material Adverse Effect on Wellmont or on any of the Wellmont Subsidiaries. There is not pending, nor to the Knowledge of Wellmont, threatened, any proceeding or investigation under the Government Programs or TRICARE involving Wellmont or the Wellmont Facilities. The cost reports of Wellmont and the Wellmont Facilities for the Government Programs for the fiscal years through June 30, 2014 and for subsequent periods that are required to be filed on or before the Effective Date have been or will be properly filed and, to the Knowledge of Wellmont, are or will be complete and correct in all material respects. Wellmont and the Wellmont Subsidiaries are in material

compliance with filing requirements with respect to cost reports of the Wellmont Facilities and, to the Knowledge of Wellmont, such reports do not claim, and none of the Wellmont Facilities have received payment or reimbursement in excess of the amount provided by federal or state law or any applicable agreement, except where excess reimbursement was noted on the cost report. Except for claims, actions, and appeals in the ordinary course of business, there are no material claims, actions, or appeals pending before any commission, board, or agency, including any contractor, fiscal intermediary, or carrier, or Governmental Entity, with respect to any Government Program cost reports or claims filed with respect to the Wellmont Facilities, on or before the date of this Agreement, or any disallowances by any commission, board, or agency in connection with any audit of such cost reports.

(c) Except as disclosed in the Wellmont Counsel Memorandum or disclosed to MSHA prior to the date hereof through the Black Box Process, to the Knowledge of Wellmont, all billing practices of Wellmont and the Wellmont Subsidiaries with respect to the Wellmont Facilities to all third party payors, including the Government Programs, TRICARE, and private insurance companies, have been in compliance with all applicable federal and state laws, regulations, and polices of such third party payors and Government Programs in all material respects, and (to the Knowledge of Wellmont) neither Wellmont nor the Wellmont Facilities have billed or received any payment or reimbursement in excess of amounts allowed by state or federal law.

(d) Except as set forth in the Wellmont Counsel Memorandum, each Wellmont Facility eligible for such accreditation is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or other appropriate accreditation agency.

(e) Neither Wellmont nor any of the Wellmont Subsidiaries nor (to the Knowledge of Wellmont) any member, trustee, officer, or employee of Wellmont or any of the Wellmont Subsidiaries, nor any agent acting on behalf of or for the benefit of any of the foregoing, has directly or indirectly in connection with any of the Wellmont Facilities; (i) offered or paid, solicited or received, any remuneration, in cash or in kind, to or from, or made any financial arrangements with, any past, present, or potential customers, past or present suppliers, patients, physicians, contractors, or third party payors of Wellmont or any of the Wellmont Facilities in order to induce referrals or otherwise generate business or obtain payments from such Persons to the extent any of the foregoing is prohibited by federal or state law; (ii) given or agreed to give, or is aware that there has been made or that there is any agreement to make, any gift or gratuitous payment of any kind, nature, or description (whether in money, property, or services) to any customer or potential customer, supplier, or potential supplier, contractor, third party payor, or any other Person to the extent any of the foregoing is prohibited by federal or state law; (iii) made or agreed to make, or is aware that there has been made, or that there is any agreement to make, any contribution, payment, or gift of funds or property to, or for the private use of, any governmental official, employee, or agent where either the contribution, payment, or gift or the purpose of such contribution, payment, or gift is or

was illegal under the laws of the United States or under the law of any state or any other Governmental Entity having jurisdiction over such payment, contribution, or gift; (iv) established or maintained any unrecorded fund or asset for any purpose or made any misleading, false, or artificial entries on any of its books or records for any reason; or (v) made, or agreed to make, or is aware that there has been made, or that there is any agreement to make, any payment to any Person with the intention or understanding that any part of such payment would be used for any purpose other than that described in the documents supporting such payment.

(f) Neither Wellmont nor any of the Wellmont Subsidiaries, nor (to the Knowledge of Wellmont) any member, trustee, officer, or employee of Wellmont nor any of the Wellmont Subsidiaries, is a party to any contract, lease agreement, or other arrangement (including any joint venture or consulting agreement) related to Wellmont or any of the Wellmont Facilities with any physician, health care facility, hospital, nursing facility, home health agency, or other Person who is in a position to make or influence referrals to or otherwise generate business for Wellmont with respect to any of the Wellmont Facilities, to provide services, lease space, lease equipment, or engage in any other venture or activity, to the extent that any of the foregoing is prohibited by any federal or state law.

(g) Wellmont represents and warrants to MSHA that neither it nor any of the Wellmont Subsidiaries: (i) is currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) is or has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) is, to the Knowledge of Wellmont, under investigation with respect to matters which may result in such party being excluded from participation in the Federal health care programs.

Section 3.18 Minute and Stock Transfer Books. The minute books of Wellmont and the Wellmont Subsidiaries are true, correct, complete, and current in all material respects, and contain accurate and complete records of all material actions taken by their respective Boards of Directors, Members or Managers and, in the case of for-profit Wellmont Subsidiaries, their respective shareholders. All signatures contained in such minute books are the true signatures of the persons whose signatures they purport to be. The stock (or other equity) transfer books of each for-profit Wellmont Subsidiary are true, correct, complete, and current in all respects.

Section 3.19 Records. All records, technical data, asset ledgers, books of account, inventory records, budgets, supplier records, payroll and personnel records, computer programs, correspondence, and other files of Wellmont and the Wellmont Subsidiaries are true, accurate, and complete in all material respects and those items that are subject to generally accepted accounting principles have been maintained in all material respects in accordance therewith.

Section 3.20 No Other Representations or Warranties. None of Wellmont nor any affiliate thereof, nor any of their agents (financial, legal or otherwise), makes or has made any representations or warranties, express or implied, of any nature whatsoever relating to Wellmont or the Wellmont Subsidiaries or the business of Wellmont and the Wellmont Subsidiaries or otherwise in connection with the transactions contemplated by this Agreement, other than those representations and warranties of Wellmont expressly set forth in this ARTICLE III. Wellmont hereby expressly disclaims, and MSHA acknowledges that it is not relying on, any other express or implied representations or warranties with respect to any matter whatsoever, including any express or implied representation or warranty as to the completeness of the information contained in this Agreement. Without limiting the generality of the foregoing, MSHA acknowledges that none of Wellmont nor any affiliate or agents thereof has made, and shall not be deemed to have made, any representations or warranties, express or implied, in, or concerning the accuracy or completeness of, the materials relating to the business of Wellmont and the Wellmont Subsidiaries made available to MSHA and its affiliates and agents, including due diligence materials, or in any presentation about the business of Wellmont and the Wellmont Subsidiaries by Wellmont, management of Wellmont or others in connection with the transactions contemplated by this Agreement, and no statement contained in any of such materials or made in any such presentation shall be a representation or warranty hereunder or otherwise or be relied upon by MSHA in executing, delivering and performing this Agreement. MSHA acknowledges that any cost estimates, projections or other predictions, any data, any future financial information or any memoranda or offering materials or presentations, including but not limited to, any confidential information memorandum or similar materials made available by Wellmont, its affiliates or agents are not and shall not be deemed to be or to include representations or warranties of Wellmont, and are not and shall not be relied upon by MSHA or its affiliates in executing, delivering and performing this Agreement. Furthermore, Wellmont and MSHA each hereby acknowledge that this Agreement embodies the justifiable expectations of sophisticated parties derived from arm's-length negotiations; all parties to this Agreement specifically acknowledge that no party has any special relationship with another party that would justify any expectation beyond that of an ordinary buyer and an ordinary seller in an arm's-length transaction.

Article IV Representations and Warranties of MSHA.

Subject to the limitations and qualifications set forth in this Agreement, MSHA represents and warrants to Wellmont the matters set forth below. Statements by MSHA with respect to the MSHA Subsidiaries (as defined in Section 4.03) refer to all of its subsidiaries.

Section 4.01 Effect of Agreement. Assuming the due execution and delivery of this Agreement by Wellmont, this Agreement is a legal, valid, and binding obligation of MSHA and is enforceable against it in accordance with its terms, except as enforceability may be restricted, limited or delayed by applicable bankruptcy or other laws affecting creditors' rights generally and except as enforceability may be subject to general principles of equity. Except as set forth in a confidential communication delivered by MSHA legal counsel to Wellmont legal counsel prior to the date of this Agreement (the "MSHA Counsel Memorandum"), the execution, delivery and performance of this Agreement by MSHA are within its corporate powers. Except as set forth in

the MSHA Counsel Memorandum, or otherwise expressly provided in this Agreement, the execution, delivery, and performance of this Agreement by MSHA and the consummation of the transactions contemplated hereby by MSHA will not: (i) require the consent, approval, or authorization of any person, corporation, partnership, joint venture, or other business association or public authority; (ii) violate any provisions of law applicable to MSHA or to any of the MSHA Subsidiaries now or immediately prior to the Effective Date; (iii) with or without the giving of notice or the passage of time, or both, conflict with or result in a breach or termination of any provision of, or constitute a material default under, or result in the creation of any lien, charge, or encumbrance upon any of the properties or assets of MSHA or any of the MSHA Subsidiaries pursuant to, any corporate charter, bylaw, indenture, note, bond, pledge, mortgage, deed of trust, lease, license, contract, agreement, commitment, or other instrument or obligation, or any order, judgment, award, decree, statute, ordinance, or regulation, to which MSHA or any of the MSHA Subsidiaries is a party or by which MSHA or any of the MSHA Subsidiaries or any of their respective material assets or properties may be bound; or (iv) result in the acceleration of any indebtedness of MSHA or any of the MSHA Subsidiaries or increase the rate of interest payable by MSHA or by any of the MSHA Subsidiaries with respect to any indebtedness.

Section 4.02 Organization; Power; Good Standing. MSHA is a nonprofit corporation duly organized and validly existing under the laws of the State of Tennessee and has all requisite corporate power and authority to own, lease, and operate its properties, to carry on its business as now being conducted, and to enter into this Agreement and perform its obligations hereunder. True and correct copies of the Articles of Incorporation and Bylaws or Articles of Organization and Operating Agreements, as applicable, of each of MSHA and the MSHA Subsidiaries have been provided to Wellmont. Neither the character of the properties owned or leased by MSHA nor the nature of the business conducted by MSHA requires the licensing or qualification of MSHA as a corporation in any jurisdiction other than the State of Tennessee and the Commonwealth of Virginia.

Section 4.03 MSHA Subsidiaries. Other than as disclosed in Schedule 4.03 of the MSHA Counsel Memorandum, MSHA does not directly or indirectly own any interest in any other corporation, partnership, joint venture, or other business association or entity, foreign or domestic. Such corporations, partnerships, joint ventures, or other business entities set forth in the MSHA Counsel Memorandum of which it owns, directly or indirectly, more than fifty percent (50%) of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests) are referred to herein each as a "MSHA Subsidiary" or collectively as "MSHA Subsidiaries." Set forth in the MSHA Counsel Memorandum is an indication of the interest owned by MSHA in each corporation, partnership, joint venture, or other business association or entity in which MSHA owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests). With respect to the MSHA Subsidiaries, MSHA on behalf of itself and the MSHA Subsidiaries, represents and warrants the following:

(a) Each MSHA Subsidiary that is a corporation is a corporation duly organized, validly existing, and in good standing under the laws of the jurisdiction of its

incorporation. Each MSHA Subsidiary that is a limited liability company is duly formed and validly existing under the laws of its jurisdiction of formation.

(b) Each MSHA Subsidiary has the corporate power, or power under the Tennessee Limited Liability Company Act or the Virginia Limited Liability Company Act, as the case may be, and its internal governing documents, as applicable, and authority to own, lease, and operate its properties and to carry on its business as presently conducted or presently proposed to be conducted.

(c) Each MSHA Subsidiary is duly qualified to do business as a foreign corporation or limited liability company, as the case may be, and is in good standing, in each jurisdiction where the character of its properties owned or held under lease or the nature of its activities makes such qualification necessary.

(d) All of the outstanding shares of capital stock or other equity interests of the MSHA Subsidiaries that are for-profit entities and all membership interests in non-profit entities are, in each case, validly issued, fully paid, and non-assessable.

(e) All of the outstanding shares of capital stock of, or other ownership or membership interests in, each of the MSHA Subsidiaries owned by MSHA or by any of its MSHA Subsidiaries are so owned free and clear of any liens, claims, charges, or encumbrances. There are no outstanding options, warrants, subscriptions, calls, rights, convertible securities, or other agreements or commitments obligating MSHA or any of the MSHA Subsidiaries to issue, transfer, or sell any securities of any MSHA Subsidiary.

(f) There are no voting trusts, standstill, shareholder, partnership, operating, or other agreements or understandings to which MSHA or an MSHA Subsidiary is a party or is bound with respect to the voting of the capital stock or other ownership interest in any MSHA Subsidiary.

Section 4.04 Financial Statements. MSHA has delivered to Wellmont, or will deliver to Wellmont within five (5) days of becoming available, copies of (i) its audited consolidated financial statements for the years ended June 30, 2013 and June 30, 2014 and for each year thereafter through the Effective Date, as presented by the auditors regularly retained by MSHA, together with any management letters issued by the auditors in connection with the foregoing and a written copy of all material presented to the Audit Committee of the MSHA Board, and (ii) its unaudited interim consolidated financial reports for the year ended June 30, 2015, and the two months ended August 31, 2015 and each month thereafter through the Effective Date. Such financial statements, together with the notes thereto, and such interim unaudited consolidated financial reports (collectively, the "Financial Statements"), are in accordance with the books and records of MSHA; and except as otherwise set forth in the MSHA Counsel Memorandum, fairly present in all material respects the financial position of MSHA and the results of operations and cash flows for the years then ended or other periods indicated in conformity with GAAP applied on a consistent basis throughout such periods, except to the extent that the interim unaudited consolidated financial reports contain no notes and are subject to year-end audit adjustments that

are not, individually or in the aggregate, material and, except as noted in such statements, consistent with prior periods. The most recent balance sheet of MSHA included in its Financial Statements is referred to herein as its "Balance Sheet." The "Balance Sheet Date" shall mean June 30, 2015.

Section 4.05 Absence of Undisclosed Liabilities. Other than with respect to matters addressed in Section 4.17, representations concerning which are contained only in Section 4.17, except as expressly disclosed or reserved against on the Balance Sheet or as specifically set forth in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries had, as of the Balance Sheet Date, any debts, liabilities, or obligations of any nature, whether accrued, absolute, contingent, or otherwise, and whether due or to become due, including, but not limited to, guarantees, liabilities, or obligations on account of Taxes (as defined in Section 4.08 below), other governmental charges, duties, penalties, interest, fines, or obligations to refund, required in accordance with GAAP to be disclosed on the Balance Sheet.

Section 4.06 Absence of Certain Changes. Except as set forth in the MSHA Counsel Memorandum, as disclosed to Wellmont prior to the date hereof through the Black Box Process, or as permitted by this Agreement, since the Balance Sheet Date, MSHA has suffered no Material Adverse Effect (as defined in Section 3.06).

Section 4.07 Contracts. The MSHA Counsel Memorandum contains a list of all contracts, agreements, commitments, and arrangements to which MSHA or any of the MSHA Subsidiaries are a party or by which any of their assets are bound or affected that: (i) involve the expenditure by MSHA or any of the MSHA Subsidiaries thereto of more than $250,000 on an annual basis; (ii) to the Knowledge of MSHA, are with, or relate to, any physician; or (iii) to the Knowledge of MSHA, are with, or relate to, any Disqualified Person within the meaning of Section 4958(f) of the Code (each a “MSHA Material Contract”). "Knowledge of MSHA" when used in this Agreement means the actual knowledge of the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, or the General Counsel of MSHA. For avoidance of doubt, the term Disqualified Person shall include persons (including any physicians or their family members) who are or were, at any time during the five-year period ending on the Effective Date: (a) voting members of the subject organization’s governing body; (b) presidents, chief executive officers, chief operating officers, and other persons with ultimate responsibility for implementing the decisions of the governing body or for supervising the management, administration, or operation of the organization, regardless of title; (c) treasurers and chief financial officers and other persons with ultimate responsibility for managing the finances of the organization, regardless of title; (d) in a position to exercise substantial influence over the subject organization’s affairs, including (i) persons who have or share authority to control or determine a substantial portion of the organization’s capital expenditures, operating budget, or compensation for employees, (ii) persons who manage a discrete segment or activity of the organization that represents a substantial portion of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole, (iii) persons who are substantial contributors to the organization (within the meaning of Code Section 507(d)(2)(A)), taking into account only contributions received by the organization during its current taxable year and the four preceding taxable years; and (iv) persons whose compensation is primarily based on revenues derived from

activities of the organization, or of a particular department or function of the organization, that the person controls; (e) family members of persons meeting a definition in (a)-(d) above (for this purpose, "family members" are limited to the following: spouse, brothers or sisters (by whole or half-blood), spouses of brothers or sisters (by whole or half-blood), ancestors, children, grandchildren, great grandchildren, and spouses of children, grandchildren, and great grandchildren); and (f)(i) a corporation in which persons described in (a)-(e) own more than 35 percent of the combined voting power; (ii) a partnership in which persons described in (a)-(e) own more than 35 percent of the profits interests; or (iii) a trust or estate in which persons described in (a)-(e) own more than 35 percent of the beneficial interests. Other than as set forth in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has entered into any MSHA Material Contract. All MSHA Material Contracts are valid and enforceable in accordance with their terms, except as such enforceability may be limited by bankruptcy, insolvency, receivership, and other laws affecting creditors' rights generally and general principles of equity. MSHA and the MSHA Subsidiaries and, to the Knowledge of MSHA, all other parties to each of the foregoing arrangements, have performed in all material respects their respective obligations to date required to be performed under each MSHA Material Contract. Except as disclosed in the MSHA Counsel Memorandum, neither MSHA or any of the MSHA Subsidiaries nor, to the Knowledge of MSHA, any other party, is in default or in arrears in any material respect under the terms of any of the foregoing arrangements, and no condition exists or event has occurred that, with the giving of notice or the lapse of time or both, would constitute a material default under any of them. Except as noted to the contrary in the MSHA Counsel Memorandum, none of the rights of MSHA or any of the MSHA Subsidiaries under any of such agreements is subject to termination or modification as the result of the transactions contemplated by this Agreement. Correct and complete copies of all written contracts referenced in the MSHA Counsel Memorandum and true and complete summaries of any oral contracts or other arrangements therein referenced have been made available to Wellmont.

Section 4.08 Tax Matters. For purposes of this Section:

(a) "Tax" or "Taxes" means any federal, state, or local income (including unrelated business income), gross receipts, license, payroll, employment, excise, severance, stamp, occupation, premium, environmental (including taxes under Code Section 59A), capital stock, franchise, profits, withholding, social security (or similar), unemployment, disability, real property, personal property, sales, use, transfer, registration, estimated, or other tax of any kind whatsoever, including any interest, penalty, or addition thereto, whether disputed or not.

(b) "Tax Return" means any return, declaration, report, claim for refund, or information return or statement relating to Taxes, including any schedule or attachment thereto, and including any amendment thereof.

(c) MSHA and the MSHA Subsidiaries will have timely filed all federal income tax returns and all other material Tax Returns that they are required to file before the Effective Date. All such Tax Returns are correct and complete in all material respects. All material Taxes due and owing by MSHA and the MSHA Subsidiaries have been paid

or reserved against in such party's Financial Statements. Neither MSHA nor the MSHA Subsidiaries currently are the beneficiary of any extension of time within which to file any Tax Return except as set forth the MSHA Counsel Memorandum. No written claim has been made within the last 3 years by an authority in a jurisdiction where MSHA or the MSHA Subsidiaries do not file Tax Returns that they are or may be subject to taxation by that jurisdiction.

(d) MSHA and the MSHA Subsidiaries have withheld and paid all Taxes required to have been withheld and paid in connection with amounts paid or owing to any employee, independent contractor, creditor, stockholder, or other third party.

(e) There is no material dispute or claim concerning any Tax liability of MSHA or any entity listed in the MSHA Counsel Memorandum either: (i) claimed or raised by any governmental authority in writing and brought to the attention of any of the directors, officers, or employees responsible for Tax matters of MSHA and the MSHA Subsidiaries; or (ii) as to which any of the directors, officers, or employees responsible for Tax matters of MSHA and the MSHA Subsidiaries has knowledge based upon personal contact with any agent of such governmental authority. Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries is the subject of an audit or examination by any governmental authority with respect to its potential liability for Taxes.

(f) Neither MSHA nor the MSHA Subsidiaries has waived any statute of limitations in respect of Taxes or agreed to any extension of time with respect to a Tax assessment or deficiency.

(g) Other than as set forth in the MSHA Counsel Memorandum, MSHA and each of the MSHA Subsidiaries is not a party to and have no continuing obligations under any Tax allocation or sharing agreement. MSHA and each of the MSHA Subsidiaries: (i) have not been members of an affiliated group (within the meaning of Code § 1504(a)) filing a consolidated federal income Tax Return, and (ii) have no liability for the Taxes of any entity or unincorporated organization (other than MSHA and the MSHA Subsidiaries) under Treasury Regulation § 1.1502-6 (or any similar provision of state, local, or foreign law), as a transferee or successor, by contract or otherwise.

(h) The unpaid Taxes of MSHA and the MSHA Subsidiaries: (i) did not, as of the Balance Sheet Date, exceed by any material amount the reserve for Tax liability (excluding any reserve for deferred Taxes established to reflect timing differences between book and Tax income) set forth on the face of the Balance Sheet as of the Balance Sheet Date (rather than in any notes thereto), and (ii) will not exceed by any material amount that reserve as adjusted for the passage of time through the Effective Date in accordance with the past custom and practice of MSHA and the MSHA Subsidiaries in filing its Tax Returns.

(i) MSHA and the MSHA Subsidiaries that claim to be tax-exempt under Code Section 501(c)(3) (for purposes of this Section 4.08.(i) only, the "Tax-Exempt MSHA Subsidiaries") have, by reason of letters from the Internal Revenue Service, been determined by the Internal Revenue Service to be exempt from federal income taxation under Code Section 501(c)(3) and not to be private foundations under Code Section 509(a). MSHA has no Knowledge of any facts or circumstances which would cause the Internal Revenue Service to revoke such determinations or to conclude that MSHA or the Tax Exempt MSHA Subsidiaries are "private foundations" as defined in Code Section 509(a). MSHA has no Knowledge of any facts or circumstances indicating that any part of the net earnings of MSHA or the Tax Exempt MSHA Subsidiaries inures to the benefit of any private member or individual, within the meaning of Code Section 501(c)(3). Neither MSHA nor the Tax-Exempt MSHA Subsidiaries has taken or permitted any action that would subject MSHA or any Tax-Exempt MSHA Subsidiary to penalty excise taxes (also known as "Intermediate Sanctions") under the Taxpayer Bill of Rights 2 (Pub. L. No. 104-168, 110 Stat. 1452).

Section 4.09 Title to Properties. MSHA and the MSHA Subsidiaries have good and marketable title to, or a valid leasehold interest in, all their real and personal property and other assets, tangible and intangible, subject to no security interest, pledge, lien, encumbrance, claim, charge, or other restrictions other than; (a) those incurred in the ordinary course of MSHA's business, including those related to debt obligations of MSHA reflected in the Financial Statements, and (b) "Permitted Liens." For the purposes of this Agreement, "Permitted Liens" shall mean; (i) easements that do not materially adversely affect the full use and enjoyment of the Owned Real Property (as defined in Section 4.13 below) or Leased Real Property (as defined in Section 4.13 below) for the purposes for which it is currently used or materially detract from its value; (ii) imperfections of title and encumbrances, if any, individually or in the aggregate, which are not material, do not materially detract from the marketability or value of the properties subject thereto, and do not materially impair the operations of the owner thereto; (iii) liens for taxes not yet due and payable; and (iv) liens incurred in the ordinary course of business in connection with governmental insurance or benefits or to secure performance of leases and contracts (other than for borrowed money) which liens do not, individually or in the aggregate, materially and adversely affect the full use and enjoyment of the properties to which they are attached.

Section 4.10 Litigation. The MSHA Counsel Memorandum contains a true and correct listing of all material litigation, administrative, arbitration, and other proceedings in which MSHA or any of the MSHA Subsidiaries is currently involved, and all court decrees or administrative orders to which MSHA or any of the MSHA Subsidiaries is subject. Other than as shown in the MSHA Counsel Memorandum or as disclosed to Wellmont prior to the date hereof through the Black Box Process,, there is no claim, action, suit, proceeding (legal, administrative, or otherwise), investigation, or inquiry (by an administrative agency, governmental body, or otherwise) pending as to which MSHA has been served process or otherwise notified or, to the Knowledge of MSHA, threatened in writing by or against, MSHA or any of the MSHA Subsidiaries, their properties or assets, or the transactions contemplated hereby, at law or in equity, or before or by any federal, state, municipal, or other governmental

department, commission, board, agency, instrumentality, or authority, domestic or foreign, the result of which could reasonably be expected to have a Material Adverse Effect.

Section 4.11 Compliance with Law. Other than with respect to matters addressed in Section 4.17, representations concerning which are contained only in Section 4.17, and except as set forth in the MSHA Counsel Memorandum or disclosed to Wellmont prior to the date hereof through the Black Box Process, MSHA and the MSHA Subsidiaries are in compliance in all material respects with all applicable laws, rules, regulations, and licensing requirements of all federal, state, local, and foreign authorities.

Section 4.12 Permits and Licenses. MSHA and the MSHA Subsidiaries maintain in full force and effect all permits, licenses, orders, and approvals necessary for them to carry on their respective businesses as presently conducted other than such permits, licenses, orders, and approvals the absence of which, individually or in the aggregate, has not had and would not reasonably be expected to have a Material Adverse Effect. All fees and charges incident to such permits, licenses, orders, and approvals have been fully paid and are current, and no suspension or cancellation of any such permit, license, order, or approval has been threatened or could result by reason of the transactions contemplated by this Agreement. Neither MSHA nor any of the MSHA Subsidiaries have received any notice from any Governmental Entity that any MSHA Facilities are not in substantial compliance with all of the terms, conditions, and provisions of such permits, consents, approvals, or licenses. MSHA heretofore has made available to Wellmont correct and complete copies of all such permits, consents, orders, approvals, and licenses. A list of all permits, licenses, orders, and approvals held by MSHA and the MSHA Subsidiaries is set forth in the MSHA Counsel Memorandum.

Section 4.13 Real Property.

(a) Owned. Except as set forth in the MSHA Counsel Memorandum, MSHA and the MSHA Subsidiaries have good and marketable title to all real property reflected on their respective balance sheets (collectively, the "Owned Real Property"). Except as set forth in the MSHA Counsel Memorandum, (i) neither MSHA nor any MSHA Subsidiary has agreed, orally or in writing, or is otherwise obligated, to sell, lease, encumber, or otherwise dispose of any of the Owned Real Property; and (ii) other than tenant leases in the ordinary course of operations, no person or entity has any leasehold interest in, and no person or entity (other than MSHA or a MSHA Subsidiary) has any right to use, operate, or occupy any of the Owned Real Property.

(b) Leased. With respect to all real property leased by MSHA or the MSHA Subsidiaries and which (i) involve the expenditure by MSHA or any of the MSHA Subsidiaries thereto of more than $250,000 on an annual basis or (ii) to the Knowledge of MSHA, are with, or relate to, any physician (collectively, the "Leased Real Property") and all leases relating thereto (collectively, the "Real Property Leases"), MSHA represents and warrants that except as set forth in the MSHA Counsel Memorandum, (i) each Real Property Lease is valid, binding, and enforceable in accordance with its terms and is in full force and effect, and there are no offsets or defenses by either landlord or

tenant thereunder; (ii) there are no existing breaches of or defaults under, and no events or circumstances have occurred which, with or without notice or lapse of time, or both, would constitute a breach of or a default under, any of the Real Property Leases; and (iii) consummation of the Affiliation will not constitute or result in a breach or default under any Real Property Lease. A list of all Real Property Leases of MSHA and the MSHA Subsidiaries is set forth in the MSHA Counsel Memorandum.

(c) Improvements. The Owned Real Property and the Leased Real Property are zoned for the various purposes for which the buildings and other improvements located thereon (the "Improvements") are presently being used, except in the case of permitted nonconforming uses. All of the Improvements and all uses thereof are in material compliance with all applicable zoning and land use laws, ordinances, and regulations. No part of any of the Improvements encroach on any real property not included in the Owned Real Property or the Leased Real Property in such a way that the remediation of the encroachment would prevent MSHA's continued use of the Improvements to such an extent as to materially affect such Party's operations.

Section 4.14 Environmental Protection. Except as set forth in the MSHA Counsel Memorandum, and to the Knowledge of MSHA:

(a) MSHA and the MSHA Subsidiaries are in compliance in all material respects with federal, state, and local environmental laws and regulations that are applicable to MSHA and the MSHA Subsidiaries and to their respective business operations.

(b) No substances that are defined and regulated by applicable environmental laws and regulations as toxic substances, hazardous wastes, hazardous materials, or hazardous substances (including, without limitation, asbestos, and petroleum and its constituents) (collectively, "Hazardous Substances") have been stored, disposed of, or released in or on the Owned Real Property, the Leased Real Property, the Improvements, or other assets of MSHA or the MSHA Subsidiaries in any manner, locations, or amounts that are outside of the ordinary course of business for MSHA and the MSHA Subsidiaries, or that violate applicable environmental laws and regulations, or that create material response duties or material cleanup liability for MSHA or any of the MSHA Subsidiaries.

(c) MSHA and the MSHA Subsidiaries have received no written notices regarding any potential claims, costs, or liabilities being asserted or to be asserted against MSHA or the MSHA Subsidiaries arising from or related to the off-site transport or disposal of Hazardous Substances from the owned Real Property or the Lease Real Property.

Section 4.15 Insurance. Other than as set forth in the MSHA Counsel Memorandum, MSHA and the MSHA Subsidiaries maintain in force valid, binding, and enforceable insurance policies providing adequate coverage for all risks normally insured against by others in the

businesses of MSHA and the MSHA Subsidiaries. All premiums due thereon have been paid and will be paid through the Effective Date. Neither MSHA nor any of the MSHA Subsidiaries has been refused any insurance by any insurance carrier during the past two years. All insurance policies maintained by MSHA and by the MSHA Subsidiaries are described in the MSHA Counsel Memorandum.

Section 4.16 Employees; Benefit Plans.

(a) Except as set forth in the MSHA Counsel Memorandum, there are no Plans, as defined below, contributed to, maintained, or sponsored by MSHA or any of the MSHA Subsidiaries, to which MSHA or any MSHA Subsidiary is obligated to contribute or with respect to which it has any current or future obligation or liability, including all Plans contributed to, maintained, or sponsored in the past six years by any current or former member of the controlled group of companies, within the meaning of Sections 414(b), 414(c), 414(m), and 414(o) of the Code, of which MSHA or any of the MSHA Subsidiaries is a member. For the purposes of this Agreement, the term "Plans" shall mean: (i) employee benefit plans as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), whether or not funded and whether or not terminated; (ii) employment agreements (exclusive of physician contracts); and (iii) personnel policies or fringe benefit plans, policies, programs, and arrangements, whether or not subject to ERISA, whether or not funded, whether written or unwritten, and whether or not terminated, including without limitation, stock bonus, deferred compensation, pension, severance, bonus, vacation, sabbatical, travel, incentive, and health, disability, and welfare plans.

(b) Except as set forth in the MSHA Counsel Memorandum, none of the Plans obligates MSHA or any of the MSHA Subsidiaries to pay separation, severance, termination, or similar-type benefits solely as a result of any transaction contemplated by this Agreement or solely as a result of a "change in control," as such term is used in Section 380G of the Code and the regulations promulgated thereunder.

(c) Except as set forth in the MSHA Counsel Memorandum, each Plan and all related trusts, insurance contracts, and funds have been maintained, funded, and administered in compliance with all applicable laws and regulations, including but not limited to ERISA and the Code. Each Plan that is intended to be a qualified retirement plan and its related trust, if any, are qualified under Code Section 401(a) and Code Section 501(a) and have been determined by the Internal Revenue Service to qualify, and nothing has occurred since the latest determination of their qualified status by the Internal Revenue Service to cause the loss of such qualification. In addition to the foregoing, each Plan that is intended to be a tax-deferred annuity plan within the meaning of Code Section 403(b), has been administered in accordance with the provisions of that Section. Except as set forth in the MSHA Counsel Memorandum, no Plan that is qualified under Code Section 401(a) has ever been merged with or accepted transfers from another Plan under Code Section 414(1).

(d) MSHA has provided to Wellmont the latest actuarial valuation report for each Plan that is a defined benefit pension plan and the most recent information on contributions and the fair market value of the assets for each Plan. All financial and employee census data, and all other information provided by MSHA to the actuaries for each such Plan in order to prepare the latest actuarial report for each such Plan was true, correct and complete in all material respects. With respect to each Plan that is subject to the funding requirements of Section 412 of the Code and Section 302 of ERISA, all contributions required to have been made for all periods ending prior to or as of the Effective Date (including periods from the first day of the then-current plan year to the Effective Date) have been made, and no accumulated funding deficiency (as defined in Code Section 412(a)) has been incurred, without regard to any waiver granted under Code Section 412. With respect to each other Plan, all required payments, premiums, contributions, reimbursements, or adequate accruals for all periods ending prior to or as of the Effective Date have been made within the time due. Except as set forth in the MSHA Counsel Memorandum, no Plan which is a qualified retirement plan within the meaning of Section 401(a) of the Code ("Qualified Plan") has any material unfunded liabilities.

(e) There have been no prohibited transactions with respect to any Plan which could result in liability to the Representing Party, any of the MSHA Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. There has been no breach of fiduciary duty (including violations under Part 4 of Title I of ERISA) with respect to any Plan which could result in liability to the Representing Party, any of the MSHA Subsidiaries, or any of their respective employees that, individually or in the aggregate, could have a Material Adverse Effect. No action, suit, proceeding, hearing, or investigation relating to any Plan (other than routine claims for benefits) is pending or has been threatened, and neither MSHA nor any of the MSHA Subsidiaries, nor any of their respective employees, has knowledge of any fact that would reasonably be expected to form the basis for such action, suit, proceeding, hearing, or investigation. Except as set forth in the MSHA Counsel Memorandum, no matters are currently pending with respect to any Plan under the Employee Plans Compliance Resolution System maintained by the Internal Revenue Service or any similar program maintained by any other government authority.

(f) Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has ever sponsored, maintained, contributed to, had any obligation to contribute to, or had any other liability under or with respect to any employee pension benefit plan covered by Title IV of ERISA, Section 302 of ERISA, or Section 412 of the Code. Neither MSHA nor any of the MSHA Subsidiaries has ever had any obligation to contribute to, participated in, or been subject to any liability under or with respect to any "multiemployer plan" as defined in Section 3(37) of ERISA or any "multiple employer welfare arrangement" as defined in Section 3(40)(A) of ERISA.

(g) Except as disclosed in the MSHA Counsel Memorandum, neither MSHA nor any of the MSHA Subsidiaries has ever sponsored, maintained, administered,

contributed to, had any obligation to contribute to, or had any other liability under or with respect to any policy, agreement, practice, or Plan which provides health, life, or other coverage for former directors, officers, or employees (or any spouse or former spouse or other dependent thereof), other than benefits required by COBRA or comparable state-mandated health plan continuation coverage.

(h) Neither MSHA nor any of the MSHA Subsidiaries has ever maintained a "voluntary employees' beneficiary association" within the meaning of Section 501(c)(9) of the Code or any other "welfare benefit fund" as defined in Section 419(e) of the Code.

(i) With respect to each Plan that is subject to COBRA and that benefits any current or former employee of MSHA or any of the MSHA Subsidiaries, MSHA or the MSHA Subsidiaries has complied in all material respects with the continuation coverage requirements of COBRA to the extent such requirements are applicable.

(j) All reports and information relating to each Plan required to be filed with a government authority have been timely filed and are accurate in all material respects, all reports and information relating to each such Plan required to be disclosed or provided to participants or their beneficiaries have been timely disclosed or provided, and there are no restrictions on the right of MSHA or any of the MSHA Subsidiaries to terminate or decrease (prospectively) the level of benefits under any Plan after the Effective Date without liability to any participant or beneficiary thereunder.

(k) Except as reflected in the MSHA Counsel Memorandum, each Plan sponsored by MSHA or any of the MSHA Subsidiaries is terminable at the discretion of such entity with no more than 30 days' advance notice and without material cost to such entity. MSHA and any of the MSHA Subsidiaries may, without material cost, withdraw their employees, directors, officers, and consultants from any Plan which is not sponsored by such entity. Except as reflected in the MSHA Counsel Memorandum, no Plan has any provision which could increase or accelerate benefits or any provision which could increase liability to Wellmont as a result of the transactions contemplated hereby, alone or together on with any other event. Except as reflected in the MSHA Counsel Memorandum, no Plan imposes withdrawal charges, redemption fees, contingent deferred sales charges, or similar expenses triggered by termination of the plan or cessation of participation or withdrawal of employees thereunder. No officer, trustee, agent, or employee of MSHA or any of the MSHA Subsidiaries has made any oral or written representation which is inconsistent with the terms of any Plan which may be binding on such Plan, the Representing Party, or any of the MSHA Subsidiaries.

(l) Each nonqualified deferred compensation plan within the meaning of Code Section 409A has been administered in compliance in all material respects with the plan terms, to the extent consistent with Code Section 409A and the applicable guidance, as described in IRS Notice 2007-86.

(m) Neither MSHA nor any of the MSHA Subsidiaries has any leased employees within the meaning of Code Section 414(n).

Section 4.17 Medicare Participation/Accreditation.

(a) For purposes of this Section:

(i) "Governmental Entity" shall mean any government or any agency, bureau, board, directorate, commission, court, department, official, political subdivision, tribunal, or other instrumentality of any government, whether federal, state, or local, domestic or foreign.

(ii) "Person" shall mean an association, a corporation, a limited liability company, an individual, a partnership, a limited liability partnership, a trust, or any other entity or organization, including a Governmental Entity.

(b) All hospitals and other health care providers owned or operated as continuing operations by MSHA or any MSHA Subsidiary (each, a "MSHA Facility," and together, the "MSHA Facilities") that make claims for payment under Title XVIII of the Social Security Act ("Medicare") and Title XIX of the Social Security Act ("Medicaid") are eligible to receive payment without restriction under Medicare and Medicaid, and is a "provider" or "supplier" with valid and current provider agreements and with one or more provider numbers with the federal Medicare program and the Medicaid program of Tennessee or Virginia (the "Government Programs") through a contractor, a fiscal intermediary, or a carrier, as applicable. Each of the MSHA Facilities that make claims for payment under TRICARE programs is a "provider" with valid and current provider agreements and with one or more provider numbers with TRICARE. Each MSHA Facility is in compliance with the conditions of participation for the Government Programs and TRICARE in all material respects and has received all approvals or qualifications necessary for capital reimbursement of the assets of MSHA or a MSHA Subsidiary, except where the failure to be in such compliance or to have such approvals or qualifications would not individually or in the aggregate have a Material Adverse Effect on MSHA or on any of the MSHA Subsidiaries. There is not pending, nor to the Knowledge of MSHA, threatened, any proceeding or investigation under the Government Programs or TRICARE involving MSHA or the MSHA Facilities. The cost reports of MSHA and the MSHA Facilities for the Government Programs for the fiscal years through June 30, 2014 and for each subsequent period required to be filed on or before the Effective Date have been or will be properly filed and, to the Knowledge of MSHA, are or will be complete and correct in all material respects. MSHA and the MSHA Subsidiaries are in material compliance with filing requirements with respect to cost reports of the MSHA Facilities and, to the Knowledge of MSHA, such reports do not claim, and none of the MSHA Facilities have received payment or reimbursement in excess of the amount provided by federal or state law or any applicable agreement, except where excess reimbursement was noted on the cost report. Except for claims, actions, and appeals in the ordinary course of business, there are no material claims,

actions, or appeals pending before any commission, board, or agency, including any contractor, fiscal intermediary, or carrier, or Governmental Entity, with respect to any Government Program cost reports or claims filed with respect to the MSHA Facilities, on or before the date of this Agreement, or any disallowances by any commission, board, or agency in connection with any audit of such cost reports.

(c) Except as set forth in the MSHA Counsel Memorandum or disclosed to Wellmont prior to the date hereof through the Black Box Process, to the Knowledge of MSHA, all billing practices of MSHA and the MSHA Subsidiaries with respect to the MSHA Facilities to all third party payors, including the Government Programs, TRICARE, and private insurance companies, have been in compliance with all applicable federal and state laws, regulations, and polices of such third party payors and Government Programs in all material respects, and (to the Knowledge of MSHA) neither MSHA nor the MSHA Facilities have billed or received any payment or reimbursement in excess of amounts allowed by state or federal law.

(d) Except as set forth in the MSHA Counsel Memorandum, each MSHA Facility eligible for such accreditation is accredited by The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or other appropriate accreditation agency.

(e) Neither MSHA nor any of the MSHA Subsidiaries nor (to the Knowledge of MSHA) any member, trustee, officer, or employee of MSHA or any of the MSHA Subsidiaries, nor any agent acting on behalf of or for the benefit of any of the foregoing, has directly or indirectly in connection with any of the MSHA Facilities; (i) offered or paid, solicited or received, any remuneration, in cash or in kind, to or from, or made any financial arrangements with, any past, present, or potential customers, past or present suppliers, patients, physicians, contractors, or third party payors of MSHA or any of the MSHA Facilities in order to induce referrals or otherwise generate business or obtain payments from such Persons to the extent any of the foregoing is prohibited by federal or state law; (ii) given or agreed to give, or is aware that there has been made or that there is any agreement to make, any gift or gratuitous payment of any kind, nature, or description (whether in money, property, or services) to any customer or potential customer, supplier, or potential supplier, contractor, third party payor, or any other Person to the extent any of the foregoing is prohibited by federal or state law; (iii) made or agreed to make, or is aware that there has been made, or that there is any agreement to make, any contribution, payment, or gift of funds or property to, or for the private use of, any governmental official, employee, or agent where either the contribution, payment, or gift or the purpose of such contribution, payment, or gift is or was illegal under the laws of the United States or under the law of any state or any other Governmental Entity having jurisdiction over such payment, contribution, or gift; (iv) established or maintained any unrecorded fund or asset for any purpose or made any misleading, false, or artificial entries on any of its books or records for any reason; or (v) made, or agreed to make, or is aware that there has been made, or that there is any agreement to make, any payment to any Person with the

intention or understanding that any part of such payment would be used for any purpose other than that described in the documents supporting such payment.

(f) Neither MSHA nor any of the MSHA Subsidiaries, nor (to the Knowledge of MSHA) any member, trustee, officer, or employee of MSHA nor any of the MSHA Subsidiaries, is a party to any contract, lease agreement, or other arrangement (including any joint venture or consulting agreement) related to MSHA or any of the MSHA Facilities with any physician, health care facility, hospital, nursing facility, home health agency, or other Person who is in a position to make or influence referrals to or otherwise generate business for MSHA with respect to any of the MSHA Facilities, to provide services, lease space, lease equipment, or engage in any other venture or activity, to the extent that any of the foregoing is prohibited by any federal or state law.

(g) MSHA represents and warrants to Wellmont that neither it nor any of the MSHA Subsidiaries: (i) is currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) is or has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) is, to the Knowledge of MSHA, under investigation with respect to matters which may result in such party being excluded from participation in the Federal health care programs.

Section 4.18 Minute and Stock Transfer Books. The minute books of MSHA and the MSHA Subsidiaries are true, correct, complete, and current in all material respects, and contain accurate and complete records of all material actions taken by their respective Boards of Directors, Members or Managers and, in the case of for-profit MSHA Subsidiaries, their respective shareholders. All signatures contained in such minute books are the true signatures of the persons whose signatures they purport to be. The stock (or other equity) transfer books of each for-profit MSHA Subsidiary are true, correct, complete, and current in all respects.

Section 4.19 Records. All records, technical data, asset ledgers, books of account, inventory records, budgets, supplier records, payroll and personnel records, computer programs, correspondence, and other files of MSHA and the MSHA Subsidiaries are true, accurate, and complete in all material respects and those items that are subject to generally accepted accounting principles have been maintained in all material respects in accordance therewith.

Section 4.20 No Other Representations or Warranties. None of MSHA nor any affiliate thereof, nor any of their agents (financial, legal or otherwise), makes or has made any representations or warranties, express or implied, of any nature whatsoever relating to MSHA or the MSHA Subsidiaries or the business of MSHA and the MSHA Subsidiaries or otherwise in connection with the transactions contemplated by this Agreement, other than those representations and warranties of MSHA expressly set forth in this ARTICLE II. MSHA hereby expressly disclaims, and Wellmont acknowledges that it is not relying on, any other express or implied representations or warranties with respect to any matter whatsoever, including any

express or implied representation or warranty as to the completeness of the information contained in this Agreement. Without limiting the generality of the foregoing, Wellmont acknowledges that none of MSHA nor any affiliate or agents thereof has made, and shall not be deemed to have made, any representations or warranties, express or implied, in, or concerning the accuracy or completeness of, the materials relating to the business of MSHA and the MSHA Subsidiaries made available to Wellmont and its affiliates and agents, including due diligence materials, or in any presentation about the business of MSHA and the MSHA Subsidiaries by MSHA, management of MSHA or others in connection with the transactions contemplated by this Agreement, and no statement contained in any of such materials or made in any such presentation shall be a representation or warranty hereunder or otherwise or be relied upon by Wellmont in executing, delivering and performing this Agreement. Wellmont acknowledges that any cost estimates, projections or other predictions, any data, any future financial information or any memoranda or offering materials or presentations, including but not limited to, any confidential information memorandum or similar materials made available by Wellmont, its affiliates or agents are not and shall not be deemed to be or to include representations or warranties of Wellmont, and are not and shall not be relied upon by MSHA or its affiliates in executing, delivering and performing this Agreement. Furthermore, Wellmont and MSHA each hereby acknowledge that this Agreement embodies the justifiable expectations of sophisticated parties derived from arm's-length negotiations; all parties to this Agreement specifically acknowledge that no party has any special relationship with another party that would justify any expectation beyond that of an ordinary buyer and an ordinary seller in an arm's-length transaction.

Article V Pre-Effective Date Covenants and Regulatory Approvals.

Section 5.01 Effective Date. Subject to the satisfaction or waiver by the appropriate Party of all the conditions precedent to Closing specified in Article VI and Article VII, the consummation of the Affiliation and the other transactions contemplated by this Agreement (the "Closing") shall take place at a mutually agreed neutral location at 10:00 A.M. local time on or before September 1, 2016 or at a mutually agreed time within five business days after all conditions have been satisfied or waived (the "Effective Date"), unless the parties hereto agree in writing upon a different time, date, or place. The parties agree that no actions to be taken on the Effective Date shall be deemed consummated until all actions required to be taken at or before Closing under this Agreement are consummated. The "Effective Time" of the Affiliation shall be the later of 12:00:01 A.M. local time on September 1, 2016 or on the date on which all actions required to be taken at Closing are consummated.

Section 5.02 Conduct of Business. Between the date hereof and the Effective Time, each of Wellmont and MSHA covenants and agrees that its business and those of its Subsidiaries will be conducted in a manner not materially different from past practice and, except as otherwise approved by MSHA or Wellmont, as the case may be, in writing, only in the ordinary course. Wellmont and MSHA shall provide, not less than five business days prior to the Effective Date, any updates to its Counsel Memorandum necessary to make then true, correct and complete as of the Effective Time.

Section 5.03 Negative Covenants.

(a) Between the date hereof and the Effective Time, Wellmont agrees that, except as otherwise agreed herein as set forth in Schedule 5.03(a) of this Agreement, or pursuant to MSHA's prior written consent, Wellmont will not and will cause each Wellmont Subsidiary not to:

(i) Except as expressly permitted herein, amend its present Articles of Incorporation or Bylaws (or other governing documents in the case of Wellmont Subsidiaries that are not corporations), sell any material portion of its assets or properties except in the ordinary course of business or change in any material manner the character of its business;

(ii) Encumber, mortgage, pledge, or suffer any lien to be placed against any of its properties or assets, except in the ordinary course of business;

(iii) Incur any indebtedness for borrowed money other than draws in the ordinary course of business against credit lines existing on the date hereof; assume, guarantee, endorse, or otherwise become responsible for the obligations of any other individual, firm, or corporation, or make any loans or advances to any individual, firm, or corporation; or make any material change in any investment allocation; or

(iv) 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 MSHA would acquire the right, directly or indirectly, to 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 its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

(b) Between the date hereof and the Effective Time, MSHA agrees that, except as otherwise agreed herein as set forth in Schedule 5.03(b) of this Agreement, or pursuant to Wellmont's prior written consent, MSHA will not and will cause each MSHA Subsidiary not to:

(i) Except as expressly permitted herein, amend its present Articles of Incorporation or Bylaws (or other governing documents in the case of MSHA Subsidiaries that are not corporations), sell any material portion of its assets or

properties except in the ordinary course of business or change in any material manner the character of its business;

(ii) Encumber, mortgage, pledge, or suffer any lien to be placed against any of its properties or assets, except in the ordinary course of business;

(iii) Incur any indebtedness for borrowed money other than draws in the ordinary course of business against credit lines existing on the date hereof; assume, guarantee, endorse, or otherwise become responsible for the obligations of any other individual, firm, or corporation, or make any loans or advances to any individual, firm, or corporation; or make any material change in any investment allocation; or

(iv) 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 Wellmont would acquire the right, directly or indirectly, to 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 its hospitals or any material portion of its assets, or provide information to any person who may be interested in any of the foregoing, or permit any trustee, officer, employee, agent, or other affiliate to do any of the foregoing.

Section 5.04 Confidentiality; Access to Books, Records, and Properties.

(a) The Parties acknowledge that they are bound by and hereby ratify and affirm the terms of the Confidentiality Agreement entered into by the parties as of April 2, 2014 (the "Confidentiality Agreement").

(b) 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.

(c) Subject to subsection (b) above, each of Wellmont and MSHA shall afford to the other Party and such Party's representatives full access to its properties, books, and records and those of its Subsidiaries during normal business hours in order that each Party may have full opportunity to make such reasonable investigation as it desires of the affairs of the other Party and its Subsidiaries, provided that such Party's right of access and inspection shall not interfere unreasonably with the business or operations of the other Party. 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, Gary Miller, Esq. or his designees and in the case of MSHA, Tim Belisle, Esq. or his designees.

(d) Except as and to the extent required by law, without the prior written consent of the other Party, neither MSHA 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 the Affiliation or any of the terms, conditions or aspects of the Affiliation except in the manner provided by the 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 Affiliation prior to the communication of the same.

Section 5.05 Regulatory Filings; Efforts to Close. Unless and until this Agreement is terminated pursuant to Article VIII, each of MSHA and Wellmont shall exercise reasonable diligence to: (a) make or obtain all consents, approvals, authorizations, registrations, and filings with all Governmental Entities or administrative agencies as are required in connection with the consummation of the transactions contemplated by this Agreement; (b) provide such other information and communications to any Governmental Entity as MSHA, Wellmont, or such Governmental Entities may reasonably request; and (c) otherwise take such actions necessary to satisfy all conditions to Closing and to Close. Without limiting the generality of the foregoing, MSHA and Wellmont shall, as promptly as practicable and in cooperation with each other, to the extent required by law, complete and file with the appropriate authorities the notification forms and any other documents, and provide such information, as required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR"), the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, §§55-531 et seq. of the Code of Virginia, and the Government Programs. MSHA and Wellmont will, and will cause their respective counsel to, supply to each other copies of all material correspondence, filings or written communications by such party or its Affiliates with any Governmental Entity or staff members thereof, with respect to the

Affiliation. Neither Party shall be required to affirmatively sue any applicable governmental agency in order to obtain the regulatory approvals required by Sections 6.05 and 7.05, nor shall either party be required to defend any action or proceeding by or before any court or other governmental body or agency which seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement.

Section 5.06 Cooperative Agreement.

(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").

(b) As promptly as practicable after the execution date hereof, Wellmont and MSHA will apply to the Tennessee Department of Health for a certificate of public advantage pursuant to the Tennessee COPA Act, and to the Southwest Virginia Health Authority and to the Virginia Department of Health for approval, pursuant to § 15.2-5384.1 of the Code of Virginia, of this Agreement as the cooperative agreement (collectively, the "Approvals"). Each of Wellmont and MSHA shall exercise reasonable diligence to obtain the Approvals.

(c) Reasonable diligence shall include each party participating diligently and continuously participating in the processes established by each of Tennessee and Virginia for the granting of the Approvals until the earlier of: (i) the date on which it is clear that the final terms and conditions of both Approvals have been established by the Tennessee and Virginia Departments of Health; or (ii) The Outside Date established by Section 8.01(b) of this Agreement. Neither Party shall be required to affirmatively sue any applicable governmental agency in order to obtain the Approvals, nor shall either party be required to defend any action or proceeding by or before any court or other governmental body or agency which seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement.

Article VI Conditions Precedent to the Obligations of MSHA.

The obligations of MSHA to consummate the Affiliation contemplated by this Agreement are, except to the extent expressly waived in writing by a party, subject to the satisfaction at or prior to the Effective Date of each of the following conditions:

Section 6.01 Accuracy of Representations and Warranties. The representations and warranties of Wellmont set forth in this Agreement shall have been true and correct on the date of this Agreement and shall be true and correct in all material respects on and as of the Effective Date, with the same force and effect as though made on and as of the Effective Date, except as affected by the transactions contemplated hereby, and there shall be delivered to MSHA on the Effective Date a certificate to such effect signed by an executive officer of Wellmont; provided that a material inaccuracy or combination of material inaccuracies of the representations and warranties of Wellmont shall not be sufficient grounds for MSHA to not consummate the

Affiliation unless the disclosed inaccuracy or inaccuracies are of a character or nature that could reasonably be expected to have a Material Adverse Effect with respect to Wellmont or that constitute grounds for not Closing under another Section of this Article VI.

Section 6.02 Performance of Agreements. Wellmont shall have performed in all material respects all obligations and agreements and complied in all material respects with all covenants and conditions contained in this Agreement to be performed or complied with by such party at or prior to the Effective Date, and there shall be delivered to each party on the Effective Date a certificate to such effect signed by an executive officer of Wellmont; provided that a material failure to perform or combination of material failures to perform shall not be sufficient grounds for MSHA to not consummate the Affiliation unless the material failure or failures to perform could reasonably be expected to have a Material Adverse Effect with respect to Wellmont or that constitute grounds for not Closing under another Section of this Article VI.

Section 6.03 Actual Actions. There shall not be any actual action or proceeding by or before any court or other governmental body or agency which (a) seeks to restrain, prohibit, or invalidate the transactions contemplated by this Agreement or (b) could reasonably be expected to materially affect the right of Parent Company, MSHA or Wellmont to own, operate, or control a material portion of their respective assets after the Effective Date.

Section 6.04 Necessary Consents; Notices. All authorizations, consents, and approvals by any third parties, including all federal, state, and local regulatory bodies and officials, that are necessary for the consummation of the transactions contemplated by this Agreement shall have been received and shall be in full force and effect; provided that, except for the condition set forth in Section 6.08, absence of one or more non-governmental third-party consents shall not be sufficient grounds for MSHA to not consummate the Affiliation unless the absence of such non-governmental third-party consent or consents could reasonably be expected to have a Material Adverse Effect or constitute grounds for not Closing under another Section of this Article VI. Without limiting the generality of the foregoing, MSHA shall not be obligated to consummate the transactions contemplated hereby unless it receives reasonably satisfactory evidence that (a) the Wellmont Board has ratified, adopted, confirmed and approved this Agreement and the transactions herein contemplated which evidence means receipt from Wellmont of a certified copy of resolutions of its Board of Directors to such effect adopted in the manner required by the law of Tennessee, and (b) all of the conditions in Section 6.05 have been satisfied.

Section 6.05 Regulatory Approvals.

(a) If applicable, the waiting period imposed by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 shall have expired or been terminated.

(b) The Attorney General and Reporter of Tennessee shall have approved the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-101, et seq.

(c) The Attorney General of Virginia shall have approved the Affiliation pursuant to §§55-531 et seq. of the Code of Virginia.

(d) The Approvals shall have been received from the Tennessee Department of Health, the Southwest Virginia Health Authority and the Virginia Department of Health.

(e) The terms and conditions of such Approvals shall be satisfactory in form and substance to the Board of Directors of MSHA.

Section 6.06 Absence of Material Adverse Change. From the date hereof through the Effective Date, there shall have not occurred any event or circumstance or combination of events or circumstances that would reasonably be expected to have a Material Adverse Effect with respect to Wellmont.

Section 6.07 Other Matters. The actions required by Sections 2.01(b),(c), (d), (e), (f), (g)(i), and (g)(ii), 2.02, and 2.05, including without limitation, preparation and attachment to this Agreement of relevant Exhibits, shall have occurred.

Section 6.08 Note Holders Waivers. The holders of the Notes shall have unconditionally waived any Event of Default resulting from or arising out of the transactions contemplated by this Agreement.

Article VII Conditions Precedent to the Obligations of Wellmont.

The obligations of Wellmont to consummate the Affiliation contemplated by this Agreement are, except to the extent expressly waived in writing by a party, subject to the satisfaction at or prior to the Effective Date of each of the following conditions:

Section 7.01 Accuracy of Representations and Warranties. The representations and warranties of MSHA set forth in this Agreement shall have been true and correct on the date of this Agreement and shall be true and correct in all material respects on and as of the Effective Date, with the same force and effect as though made on and as of the Effective Date, except as affected by the transactions contemplated hereby, and there shall be delivered to Wellmont on the Effective Date a certificate to such effect signed by an executive officer of MSHA; provided that a material inaccuracy or combination of material inaccuracies of the representations and warranties of MSHA shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the disclosed inaccuracy or inaccuracies are of a character or nature that could reasonably be expected to have a Material Adverse Effect with respect to Mountain States or that constitute grounds for not Closing under another Section of this Article VII.

Section 7.02 Performance of Agreements. MSHA shall have performed in all material respects all obligations and agreements and complied in all material respects with all covenants and conditions contained in this Agreement to be performed or complied with by such party at or prior to the Effective Date, and there shall be delivered to each party on the Effective Date a certificate to such effect signed by an executive officer of MSHA; provided that a material failure to perform or combination of material failures to perform shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the material failure or failures to perform could reasonably be expected to have a Material Adverse Effect with respect to Mountain States or that constitute grounds for not Closing under another Section of this Article VI.

Section 7.03 Actual Actions. There shall not be any actual actions or proceedings by or before any court or other governmental body or agency which (a) seek to restrain, prohibit, or invalidate the transactions contemplated by this Agreement or (b) could reasonably be expected to materially affect the right of Parent Company, MSHA or Wellmont to own, operate, or control a material portion of their respective assets after the Effective Date.

Section 7.04 Necessary Consents; Notices. All authorizations, consents, and approvals by any third parties, including all federal, state, and local regulatory bodies and officials, that are necessary for the consummation of the transactions contemplated by this Agreement shall have been received and shall be in full force and effect; provided that, except for the condition set forth in Section 7.08, absence of one or more non-governmental third-party consents shall not be sufficient grounds for Wellmont to not consummate the Affiliation unless the absence of such non-governmental third-party consent(s) could reasonably be expected to have a Material Adverse Effect or constitute grounds for not Closing under another Section of this Article VII. Without limiting the generality of the foregoing, Wellmont shall not be obligated to consummate the transactions contemplated hereby unless it receives reasonably satisfactory evidence that (a) the MSHA Board has ratified, adopted, confirmed and approved this Agreement and the transactions herein contemplated which evidence means receipt from MSHA of a certified copy of resolutions of its Board of Directors to such effect adopted in a manner required by the law of Tennessee, and (b) all of the conditions in Section 7.05 have been satisfied.

Section 7.05 Regulatory Approvals.

(a) If applicable, the waiting period imposed by the Hart-Scott-Rodino Antitrust Improvements Act of 1976 shall have expired or been terminated.

(b) The Attorney General and Reporter of Tennessee shall have approved the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-101, et seq.

(c) The Attorney General of Virginia shall have approved the Affiliation pursuant to §§55-531 et seq. of the Code of Virginia.

(d) The Approvals shall have been received from the Tennessee Department of Health, the Southwest Virginia Health Authority and the Virginia Department of Health.

(e) The terms and conditions of such approvals shall be satisfactory in form and substance to the Board of Directors of Wellmont.

Section 7.06 Absence of Material Adverse Change. From the date hereof through the Effective Time, there shall not have occurred any event or circumstance or combination of events or circumstances that would reasonably be expected to have a Material Adverse Effect with respect to Mountain States.

Section 7.07 Other Matters. The actions required by 2.01(b),(c), (d), (e), (f), (g)(i), and (g)(ii), 2.02, and 2.05, including without limitation, preparation and attachment to this Agreement of relevant Exhibits, shall have occurred.

Section 7.08 Note Holders Waivers. The holders of the Notes shall have unconditionally waived any Event of Default resulting from or arising out of the transactions contemplated by this Agreement.

Article VIII Termination.

Section 8.01 Termination. This Agreement may be terminated and the transactions contemplated hereby abandoned prior to the Closing upon the following terms:

(a) By both Parties upon their mutual written consent

(b) By either Wellmont or MSHA if Closing shall not have occurred on or before the Outside Date and, within the fourteen (14) day period immediately preceding such Outside Date, such Party gives written notice of its intent to terminate effective as of the Outside Date should Closing not have previously occurred. For purposes of this Agreement, the term "Outside Date" means the date that is one (1) year after the date of this Agreement and, unless earlier terminated as provided in this Article VIII, the expiration date of each subsequent automatic three-month extension, provided that the party electing to terminate this Agreement shall not then be in breach of this Agreement;

(c) By MSHA, if (without any breach by MSHA of any of its obligations hereunder) satisfaction of any condition to Closing set forth in Article VI becomes impossible and such failure of such satisfaction is not waived by MSHA; or

(d) by Wellmont, if (without any breach by Wellmont of any of its obligations hereunder) satisfaction of any condition to Closing set forth in Article VII becomes impossible and such failure of compliance is not waived by Wellmont.

Section 8.02 Effect of Termination. In the event of any termination of this Agreement, as provided by Section 8.01, no Party will have any further rights or obligations hereunder, except that the obligations of the parties contained in this Section 8.02 (Effect of Termination), and in Sections 5.04(a) (Confidentiality), 10.02 (Survival), 10.03 (Brokerage), 10.04 (Expenses), 10.05 (Governing Law and Venue), 10.06 (Entire Agreement), 10.07 (Amendments and Modifications), 10.08 (Assignment), 10.09 (Captions), 10.11 (Notices), 10.12 (Successors and Assigns), 10.13 (Public Announcement), 10.14 (Construction and Certain Definitions), and any related definitional provisions set forth in this Agreement shall survive and (b) termination shall not relieve any party of any liability for a breach of, or for any misrepresentation under, this Agreement, or be deemed to constitute a waiver of any available remedy (including specific performance) for any such breach or misrepresentation.

Article IX Additional Covenants.

Section 9.01 Joint Board Task Force. The Parties have formed a Joint Board Task Force, comprised of an equal number of their respective existing board members and the CEOs of each and listed on Exhibit E to oversee the pre-Closing activities of the Integration Council identified in Section 9.02 below. As promptly as practicable after the date hereof, MSHA and Wellmont will jointly select two (2) additional members of the Joint Board Task Force, neither of whom may be incumbent members of either Party's board of directors. Further, upon signing of this Agreement, the Parties will jointly invite the incumbent President of East Tennessee State University to join the Joint Board Task Force. If at any time prior to the Effective Date, the identity of the individuals who will serve as representatives of either Party on the initial NewCo Board of Directors changes, then the individuals who represent such party on the Joint Board Task Force will be modified to conform to the expected representation on the NewCo Board of Directors.

Section 9.02 Integration Council. The Parties have established an Integration Council, comprised of twelve (12) members listed on Exhibit F, to prepare the parties for integration, and, among other things, to retain an independent consultant(s) to undertake a comprehensive analysis of the clinical, operational and financial functions of Wellmont and MSHA to (a) identify, substantiate and quantify the cost-savings and quality-enhancement opportunities achievable specifically from the Affiliation and (b) help establish a timeline and integration plan for achieving these opportunities. The Integration Council retained consultant(s) (the "Consultant(s)"). Prior to Closing, the Integration Council shall:

(a) engage on a regular basis, with the Consultant(s) for periodic reports on the Consultant(s)' analysis and supply information as needed to further the analysis, and prepare the Parties for integration to ensure a system approach that best serves the needs of the community and region based on objective information; and

(b) Develop a draft Parent Company 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. Upon the Effective Time, the draft policy shall be submitted to the Board of Directors of the Parent Company for approval.

Wellmont and MSHA may jointly engage additional third-party consultants to advise the Integration Council. The Integration Council shall report to the Joint Board Task Force. All of the activities of the Integration Council prior to the Effective Time shall be reviewed by and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions. The Chief Executive Officer, in consultation with the Executive Chairman/President, shall determine whether it is in the interest of the Parent Company for the Integration Council to disband upon the Effective Date or for it to perform any specified functions post-Closing serving in the capacity of an advisory council to the Initial Management Team.

Section 9.03 Public Health Needs Assessment. After the Effective Time, Parent Company will conduct, in partnership with East Tennessee State University and other academic partners, as appropriate, a detailed public health needs assessment in order to identify and prioritize measurable health needs and initiatives. Such initiatives may include, but not be limited to:

(a) 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;

(b) Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities;

(c) Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years;

(d) Establishment of programs to improve health literacy;

(e) Development of programs to improve child wellness – physical and emotional;

(f) Growth of medical research programs; and

(g) 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 served by Parent Company and its Affiliates.

Section 9.04 Hospital and Affiliate Governance. Subject to the provisions of any existing joint venture and other contractual agreements, the governing board of all hospitals and other Affiliates will be appointed by, and serve at the pleasure of, the Parent Company Board of Directors. The Parent Company Board shall have final authority as sole member of Parent Company's ownership interest in any hospital, joint venture or partnership. Except as provided below, the existing governing boards of hospitals and Affiliates as of the Effective Time will continue to serve unless and until replaced by the Parent Company Board. To the degree any of the Boards of any subsidiary or wholly-owned organizations of Wellmont or MSHA have membership constituted to include Board Members of Wellmont or MSHA, such composition shall be modified such that initially there is an equal representation from Wellmont and MSHA. The composition of the boards of the respective physician organizations of Wellmont and MSHA will be approved by the Parent Company Board. The charters of the Wellmont and MSHA foundations will require that their respective funds as of the Effective Time be used consistent with the intent of the original donors thereof.

Section 9.05 Clinical Council.

(a) Promptly after the Closing, Parent Company will develop a physician-led clinical council (the "Clinical Council") (composed of appropriate balances of private physicians, group practice physicians and employed physicians whose initial composition is determined by the Parent Company Board of Directors) to guide, advise and assist in implementation of a 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. The initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or MSHA.

(b) The Clinical Council will include Parent Company management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Parent Company The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Parent Company-affiliated hospitals, will serve on the Quality Committee of the Parent Company Board, and will provide ongoing reports on the activities of the Clinical Council to the Parent Company Board through the Quality and Safety Committee function of the Parent Company Board.

(c) Among other duties, it is anticipated the Clinical Council will work on areas, among others, such as establishing a common standard of care, common credentialing, consistent multidisciplinary peer review, where appropriate, and quality performance standards.

Section 9.06 Corporate Headquarters. Within two (2) years of closing, the Parent Company Board of Directors will direct that Parent Company senior management evaluate the most suitable, cost-effective and appropriate location of the corporate headquarters of Parent Company and make a recommendation to the Board for consideration and approval. The Parent Company corporate headquarters shall not be located on the campus of any Parent Company affiliated hospital.

Section 9.07 Employees.

(a) After the Effective Time, all active employees of Wellmont, MSHA and their Affiliates will continue their employment at-will upon substantially similar terms and conditions with respect to base salaries and wages, job duties, titles and responsibilities that are provided to such employees immediately prior to Closing, except that certain positions that are identified as synergies may be eliminated. Normal employment practices, including terminations and reductions in force, will be unaffected.

(b) Parent Company 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 MSHA, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties' employee benefit

plans. Parent Company will provide all employees credit for accrued vacation and accumulated sick leave.

(c) Parent Company 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.

Section 9.08 Medical Staffs; Physician Contracts.

(a) Parent Company is committed to a pluralistic, physician-led medical staff model that embraces the strengths of private practice, group practice and employed physicians.

(b) All existing medical staff members in good standing at any hospital affiliated with Wellmont or MSHA immediately prior to the Effective Time shall maintain such privileges immediately after the Effective Time, subject to the medical staff bylaws then in effect. All medical staff bylaws of any such hospital will remain in effect following the Effective Time. Notwithstanding any provision herein to the contrary, no term of this Agreement shall be deemed to (i) create any contract with any member of the medical staff, (ii) give any member of the medical staff the right to retain his or her medical staff privileges after the Effective Time, (iii) interfere with the right of Wellmont, MSHA or any affiliated hospital to terminate any member of the medical staff's privileges in accordance with such hospital's then current medical staff bylaws or (iv) interfere with the right of Parent Company, Wellmont, and MSHA or any affiliated hospital to modify such hospital's medical staff bylaws.

(c) All contracts of Wellmont, MSHA, and their respective Affiliates with physicians deemed compliant with applicable law in accordance with the due diligence process followed by the Parties, including employment agreements, in effect as of the Effective Time will be performed in accordance with their terms after the Effective Time.

Section 9.09 Existing Affiliations. Parent Company will initially maintain the Wellmont and MSHA joint ventures, affiliations and other outsourced contracts/relationships existing at the Effective Time. Opportunities to optimize such structures will continue to be evaluated by the Parent Company Board and management team post-Closing.

Section 9.10 Information Technology. As soon as practicable after the Effective Time, all Parent Company hospitals will fully integrate into a common information system platform.

Section 9.11 Insurance Platforms. As soon as practicable after the Effective Time, Parent Company will review the structure of the existing insurance platforms of Wellmont and MSHA and work to spread risk, reduce costs and realize efficiencies that result from the Affiliation.

Section 9.12 Philanthropic Gifts. Parent Company will honor the intent of all gifts, bequests, grants and donations provided to either MSHA or Wellmont by a donor to be used for charitable purposes by a tax-exempt organization.

Article X Miscellaneous Provisions.

Section 10.01 Nonsurvival of Representations and Warranties. None of the representations and warranties in Articles III or IV of this Agreement shall survive the Effective Time.

Section 10.02 Survival of Covenants. All covenants contained in this Agreement that contemplate performance thereof following the Effective Time will survive for the period so contemplated by such covenant whether for a specified number of years or by reference to a specified external event or circumstance, and may be enforced during, or timely following, their duration.

Section 10.03 Brokerage. Except for Wellmont's engagement of Kaufman Hall, each of Wellmont and MSHA represents and warrants to the other that it has not dealt with any business broker, real estate agent, finder, or other third party broker or intermediary in connection with the subject of this Agreement or the transactions contemplated hereby.

Section 10.04 Expenses; Termination Payment.

(a) Except to the extent provided in Section 10.04(b), whether or not the transactions contemplated by this Agreement are consummated, MSHA shall bear seventy percent (70%) of all of the expenses incurred by MSHA or Wellmont for the accounting, legal, investment banking, and other professional services provided to either Party which arise out of the term sheet executed by the Parties effective April 2, 2015, the negotiation and preparation of this Agreement, and the transactions contemplated by, the performance of or compliance with any condition or covenant set forth in, and the consummation of the transactions provided for in, this Agreement, including Due Diligence Expenses (the "Expenses"). Wellmont shall bear thirty percent (30%) of the Expenses.

(b) Notwithstanding Section 10.04(a), Wellmont shall pay all of the amount, if any, by which Wellmont Due Diligence Expenses exceeds MSHA Due Diligence Expenses and MSHA shall pay all of the amount, if any, by which MSHA Due Diligence Expenses exceeds Wellmont Due Diligence Expenses, and the amount of Expenses subject to subsection (a) shall be reduced by the amount of such excess. "Wellmont Due Diligence Expenses" shall mean fees and expenses charged by Baker, Donelson, Bearman, Caldwell and Berkowitz, P.C. and Hunter, Smith and Davis LLP to Wellmont arising from their respective legal diligence reviews of MSHA and its Subsidiaries, and fees and expenses charged by Navigant Consulting, Inc. and others to Wellmont arising from their respective financial, business, and operational reviews of MSHA. "MSHA Due Diligence Expenses" shall mean fees and expenses charged by Seigfreid Bingham P.C. to MSHA arising from its legal diligence review of Wellmont and its Subsidiaries, and fees

and expenses charged by BKD, LLP and by Pershing Yoakley and Associates, P.C. to MSHA arising from their respective financial, business, and operational reviews of Wellmont. In order for any other expenses incurred directly by a Party to be considered its Due Diligence Expenses, such expenses shall be reviewed and determined by the Parties to be for due diligence review.

(c) Without limiting subsections (a) and (b) above, the expenses subject to this Section 10.04 shall include those the Joint Board Task Force or the Board of Directors of MSHA or Wellmont, as applicable, determine are necessary or appropriate to perform the Parties obligations specified in this Agreement. MSHA has retained an information technology consultant to conduct a comprehensive review of both party's information technology systems. The Parties agree that this review is outside the scope of the agreed cost sharing, so that MSHA will pay 100% of this expense. The Parties may also make other exceptions to the agreed upon cost sharing on a case-by-case basis.

(d) On January 29, 2016, and again within ninety (90) days after the date this Agreement is terminated, MSHA and Wellmont shall provide each other with a report setting forth all Expenses, including a separate report showing Due Diligence Expenses, incurred by them through December 31, 2015 or the date of termination, as applicable, together with such reasonable supporting detail as either Party may request, subject to such redactions as may be required to preserve attorney-client privilege, comply with HIPAA and other applicable privacy laws, or to prevent the disclosure of Competitive Sensitive Information. Not less than thirty (30) days after such reports are provided, MSHA shall pay Wellmont, or Wellmont shall pay to MSHA cash in the amount that will result in Expenses, including Due Diligence Expenses, incurred through December 31, 2015 or the termination date, as applicable, being shared in the proportions set forth in subsection (a) above, as adjusted or limited as required by subsections (b) and (c) above, and taking into account the net effect of prior interim monthly payments made by each Party to the other. Beginning February 15, 2016, within fifteen (15) days after the end of each month prior to the Effective Date, MSHA and Wellmont shall provide to each other a written report of Expenses, including a separate report showing Due Diligence Expenses, incurred through the end of the preceding month, together with such reasonable supporting detail as either Party may request, subject to such redactions as may be required to preserve attorney-client privilege, comply with HIPAA and other applicable privacy laws, or to prevent the disclosure of Competitive Sensitive Information. Not less than fifteen (15) days after such reports are provided, MSHA shall pay to Wellmont, or Wellmont shall pay to MSHA, as applicable, cash in the amount that will result in Expenses incurred through the end of the preceding month (not including the Due Diligence Expenses) being shared in the proportions set forth in subsection (a) above.

(e) In addition to any other payments required pursuant to this Section 10.04, in the event MSHA elects to terminate this Agreement pursuant to Section 8.01(c) in circumstances in which the conditions to Closing set forth in Article VI, other than the condition set forth in Section 6.05(e), have been satisfied, or Wellmont elects to terminate

this Agreement pursuant to Section 8.01(d) in circumstances in which the conditions to Closing set forth in Article VII, other than the condition set forth in Section 7.05(e), have been satisfied, the Party exercising the right to terminate shall pay to the other Party cash in an amount equal to One Million, Five Hundred Thousand Dollars ($1,500,000).

Section 10.05 Governing Law; Venue.

(a) This Agreement and the transactions contemplated herein shall be governed by, interpreted, construed, and enforced in accordance with the laws of the State of Tennessee applicable to contracts made and to be performed entirely within the State of Tennessee without giving effect to choice or conflict law provisions that would cause the application of the domestic substantive laws of any other jurisdiction.

(b) Any suit, action or other proceeding arising out of this Agreement or any transaction contemplated hereby shall be brought exclusively in the state or federal court located in the jurisdiction in which the corporate headquarters of the defending party is located (the "Proper Court"). Each party irrevocably and unconditionally waives any objection to the laying of venue of any such action, suit or proceeding in the Proper Court and further irrevocably and unconditionally waives and agrees not to plead or claim that any such action, suit or proceeding brought in the Proper Court has been brought in an inconvenient forum.

Section 10.06 Entire Agreement. This Agreement (together with the Schedules and any subsidiary documents incorporated herein) contains the entire agreement of the parties with respect to the subject matter hereof. Notwithstanding the foregoing, the parties acknowledge that they are bound by the terms of the Confidentiality Agreement, other than in cases in which it conflicts with the terms of this Agreement in which instances the terms of this Agreement shall prevail.

Section 10.07 Amendments and Modifications. This Agreement shall not be modified, amended, or changed in any respect except in writing duly signed by the parties hereto and each party hereby waives any right to amend this Agreement in any other way.

Section 10.08 Assignment. Neither party may assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of the other party.

Section 10.09 Captions. Captions in this Agreement are solely for the purposes of identification and shall not in any manner alter or vary the interpretation or construction of this Agreement.

Section 10.10 Execution in Counterparts. This Agreement 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.

Section 10.11 Notices. All notices or other communications that are required or permitted hereunder shall be given in writing and shall be given either by personal delivery, by FedEx or other overnight courier, or by facsimile, shall be deemed to have been given when personally delivered, when deposited with charges prepaid with FedEx or other nationally recognized overnight courier service, or when transmitted to a facsimile machine, addressed to the respective parties as follows:

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

With a copy (which shall not constitute notice) to:

Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660
Attn: Gary D. Miller, General Counsel

and to: Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
Attn: Richard G. Cowart, Esq.

MSHA: Mountain States Health Alliance
303 Med Tech Parkway, Suite 303
Johnson City, TN 37604
Attn: Alan Levine, President

With a copy (which shall not constitute notice) to:

Mountain States Health Alliance
303 Med Tech Parkway, Suite 370
Johnson City, TN 37604
Attn: Tim Belisle, General Counsel

Any party may by notice change the address to which notice or other communications to such party are to be delivered or mailed.

Section 10.12 Successors and Assigns. All of the terms and provisions of this Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their successors, and, to the extent permitted herein, their assigns. No third parties are intended to benefit, however, from the terms and provisions hereof or from any representation, warranty, covenant, or obligation set forth herein or in any schedule, exhibit, or other writing delivered pursuant hereto.

Section 10.13 Public Announcement. Except as and to the extent required by law, without the prior written consent of the other party, neither MSHA 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 this Agreement or any of the terms, conditions or aspects of this Agreement except in the manner provided by the 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 transactions contemplated by this Agreement prior to the communication of the same.

Section 10.14 Construction and Certain Definitions.

(a) Each party to this Agreement and its counsel have reviewed and revised this Agreement. The normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement or of any amendments or Schedules to this Agreement.

(b) References to this Agreement are references to this Agreement and to the Exhibits and Schedules to this Agreement

(c) References to any document (including this Agreement) are references to that document as amended, consolidated, supplemented, novated or replaced by the parties thereto from time to time.

(d) References to Sections and Articles are references to sections and articles of this Agreement.

(e) References to a party to this Agreement shall include its respective successors and permitted assigns.

(f) The gender of all words in this Agreement includes the masculine, feminine and neuter, and the number of all words in this Agreement include the singular and plural.

(g) The word "including" shall mean including without limitation, unless followed by the word "only."

[Signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed or caused to be executed this Agreement on the day and year first above written.

WELLMONT HEALTH SYSTEM

By: _____
Roger Leonard
Chairman of the Board of Directors

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Barbara Allen
Chairman of the Board of Directors

EXHIBITS

Exhibit A. **Affiliates**.

Exhibit B. **Shared Vision and Guiding Principles.**

Exhibit C-1. **Interim Parent Company Articles and Interim Parent Company Bylaws.**

Exhibit C-2. **Interim Directors and Interim Officers.**

Exhibit C-3 **Amended Parent Company Articles.**

Exhibit C-4 **Amended Parent Company Bylaws.**

Exhibit D-1. **Parent Company Board Officers and Initial Management Team**

Exhibit D-2. **Position Description of Executive Chairman/President**

Exhibit D-3. **Position Description of CEO**

Exhibit D-4. **Position Descriptions of COO and CFO**

Exhibit E. **Joint Board Task Force**

Exhibit F. **Integration Council**

Exhibit G. **Definitions.**

EXHIBIT A

Affiliates

MSHA AFFILIATES

Set forth below is an indication of the interest owned by MSHA in each corporation, partnership, joint venture, or other business association or entity in which MSHA owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests):

- Smyth County Community Hospital (80.0%)
- Mountain States Health Alliance Auxiliary, Inc. (100%)
- Mountain States Foundation (100%)
- Integrated Solutions Health Network (99.83%)
- Anew Care Collaborative, LLC (owned 100% by Integrated Solutions Health Network)
- CrestPoint Health Insurance Company, Inc. (owned 100% by Integrated Solutions Health Network)
- Norton Community Hospital (50.1%)
- Norton Community Physician Services, LLC (owned 100% by Norton Community Hospital)
- Dickenson Community Hospital, Inc. (owned 100% by Norton Community Hospital)
- Community Home Care, Inc. (owned 100% by Norton Community Hospital)
- Johnston Memorial Hospital, Inc. (50.1%)
- Abingdon Physician Partners (owned 100% by Johnston Memorial Hospital, Inc.)
- JMH Emergency Physicians, LLC (owned 100% by Johnston Memorial Hospital, Inc.)
- Blue Ridge Medical Management Corporation (100%)
- Mountain States Physician Group, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Mountain States Properties, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Kingsport Ambulatory Surgery Center, L.L.C. (owned 43% by Blue Ridge Medical Management Corporation)
- MediServe Medical Equipment of (owned 100% by Blue Ridge Medical Management Corporation)
- Kingsport, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- Emmaus Community Healthcare, LLC (owned 75% by Blue Ridge Medical Management Corporation)
- Wilson Pharmacy, Inc. (owned 100% by Blue Ridge Medical Management Corporation)
- The Castle Project, LLC (owned 5% by Blue Ridge Medical Management Corporation)
- Quillen Rehabilitation Hospital of Johnson City, LLC (owned 49.9% by Blue Ridge Medical Management Corporation)
- Mountain Empire Surgery Center, L.P (owned 33.86% by Blue Ridge Medical Management Corporation)

- TLC Tri-Cities Laser Center, Inc. (owned 20% by Blue Ridge Medical Management Corporation)

WELLMONT AFFILIATES

Set forth below is an indication of the interest owned by Wellmont in each corporation, partnership, joint venture, or other business association or entity in which Wellmont owns any of the outstanding membership interests, shares of capital stock, or other equity interests (including partnership interests).

- Wellmont Health System (100%)
- Wellmont Cardiology Services (100%)
- Wellmont Foundation, Inc. (100%)
- Wellmont/HealthSouth IRF, LLC (25%)
- Wellmont Madison House (100%)
- Wellmont Hawkins County Memorial Hospital, Inc. (100%)
- Wellmont Medical Associates (100%)
- Wellmont Health Management Services, Inc. (100%)
- Advanced Home Care (5.76%)
- Highlands Wellmont Health Network, Inc. (50%)
- Renaissance Surgery (33%)
- Holston Valley Ambulatory Surgery Facility, LLC (52%)
- Sapling Grove Ambulatory Surgery Facility, LLC (65%)
- Wellmont Integrated Network, LLC (100%)
- Wellmont Health Management Services, LLC (100%)
- Wellmont Imaging Services (100%)
- Holston Valley Imaging Center (100%)
- Wellmont Sleep Services (100%)
- Wellmont Wexford House (100%)
- Wellmont Insurance Company SPC, LTD (100%)
- Wellmont Inc. (100%)
- Wellmont Health Services Inc. (100%)
- Professional Park Assoc., LLC (12.72%)
- Bristol Surgery Center, LLC (100%)
- Medical Mall Pharmacy (100%)
- Medical Laundry (100%)

- MCOT, Inc. (100%)
- Wellmont Physician Services (100%)
- WPS Providers, Inc. (100%)

EXHIBIT B

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

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 C-1

Interim Parent Company Articles and Interim Parent Company Bylaws

EXHIBIT C-2

Interim Directors and Interim Officers

Directors: Barbara Allen, Roger Leonard, Roger Mowen, and Gary Peacock

Officers:

President: Alan Levine

Secretary/Treasurer: Alice Pope

EXHIBIT C-3

Amended Parent Company Articles

EXHIBIT C-4

Amended Parent Company Bylaws

EXHIBIT D-1

Parent Company Board Officers and Initial Management Team

Board Officers shall be:

(i) Executive Chairman/President: Alan Levine

(ii) Vice Chairman/Lead Independent Director: To be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force

(iii) Treasurer: To be determined by the Joint Board Task Force

(iv) Secretary: To be determined by the Joint Board Task Force

(v) Chief Executive Officer: Bart Hove

The Initial Management Team shall be:

(i) Executive Chairman/President: Alan Levine

(ii) Chief Executive Officer: Bart Hove

(iii) Chief Operating Officer: Marvin Eichorn

(iv) Chief Financial Officer: Alice Pope

Individuals appointed to the Board Officer positions identified in (ii), (iii), and (iv) above as of the Effective Time shall be set forth in an updated Exhibit E-1 to be attached hereto and initialed by the Parties on the Effective Date.

EXHIBIT D-2

Position Description of 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 the Corporation'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 Nominating 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 the Corporation.
- 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.

Relations with Stakeholders

- Ensuring effective communication with all stakeholders, financial institutions, the public and government/regulatory agencies. Serve as the Chief Spokesperson for the Corporation with appropriate delegation of authority to the CEO on operational matters.
- Representing the Corporation 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 the Corporation and on healthcare issues in general.
- Maintaining and promoting the Corporation'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 the Corporation Board and Management Team.

The Executive Chairman/President is accountable to, and reports to the Corporation's 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 Corporation Board for ensuring the provision of the highest quality of patient care and customer service in all the Corporation facilities and business units.
- Responsible for management of the organization's debt.

Aligning the organization: continuing to drive the integration of the Corporation to create a cohesive, responsive organization by eliminating redundancies, capitalizing on economies of scale, and fostering a system mentality

EXHIBIT D-3

Position Description of CEO

Leadership

- The Chief Executive Officer of the Corporation reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Corporation 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 the Corporation'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 the Corporation'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 Corporation 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 D-4

Position Descriptions of COO and CFO

Chief Operating Officer

Leadership

- The Chief Operating Officer (COO) for NEWCO reports directly to the NEWCO CEO and is responsible for the effective and efficient operations of the System and any subsidiary components as directed by the Chief Executive Officer. The COO shall ensure proper operational focus consistent with the organization's strategic plan.

- The COO provides direction to key executives and other members of the management team to ensure the objectives of the organization are met, including optimal patient experience, quality and financial outcomes.

- The COO shall communicate with clarity, and develop talent within the organization to enhance the growth of future company leaders.

Major Responsibilities

- Interface with key NEWCO operational executives, subsidiaries and corporate support functions to ensure operational effectiveness throughout the organization.

- Develop and foster effective collaboration between corporate support functions, clinical leadership, physician leadership and other functions to ensure an integrated approach to providing services and fulfilling the hospitals clinical, research and educational goals and objectives.

- Oversee major workforce and resource decisions.

- Develop new business strategies.

- Attention is to be given to systems, program development, quality, fiscal management, compliance and clinical management measures, physician relationships, outreach strategies, work culture enhancement and internal communication and consensus building.

Direct Reports

- Key corporate and operating entities shall report to the COO, as determined from time to time by the CEO in consultation with the Executive Chairman/President.

Chief Financial Officer

Leadership

- The Chief Financial Officer of NEWCO reports directly to the NEWCO CEO and is responsible for overseeing and implementing the financial strategy and operations for NEWCO. This position is responsible for financial reporting, financial compliance, budgeting, treasury management including investment and debt management, asset management including capital planning and budgeting, and payer relations.

- The position must effectively communicate and collaborate with departmental leadership, medical staff leadership, system leadership and the boards and committees of NEWCO to ensure an integrated approach to financial services.

Major Responsibilities

- Financial and strategic planning for assigned areas including but not limited to budget development, capital planning, cash forecasting, investment management/planning and payer relations.

- Foster relations between corporate entities

- Present to external audiences

Direct Reports

- Key corporate and operations finance personnel as determined from time to time by the CEO in consultation with the Executive Chairman/President

EXHIBIT E

Joint Board Task Force

MSHA
Barbara Allen
Bob Feathers
Clem Wilkes, Jr.
Gary Peacock
Dr. David May
Dr. David Moulton
Alan Levine

WHS
Roger Leonard
Roger Mowen
Keith Wilson
Dr. Nelson Gwaltney
Dr. Doug Springer
Dr. David Thompson
Bart Hove

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)
Alice Pope
Dr. Robert Funke
Dr. Dale Sargent
Todd Norris
Gary Miller

EXHIBIT G

Definitions

1.01 "Affiliation" has the meaning set forth in the Recitals.

1.02 "Agreement" has the meaning set forth in the Recitals.

1.03 "Amended Wellmont Articles" has the meaning set forth in Section 2.01(a)(ii).

1.04 "Amended Wellmont Bylaws" has the meaning set forth in Section 2.01(a)(ii).

1.05 “Approvals” has the meaning set forth in Section 5.06(b).

1.06 "Balance Sheet" has the meaning set forth in Sections 3.04. and 4.04.

1.07 “Black Box Process” has the meaning set forth in Section 3.06.

1.08 “Clinical Council” has the meaning set forth in Section 9.05(a).

1.10 “Competitive Sensitive Information” has the meaning set forth in Section 5.04.

1.11 “Consultant(s)” has the meaning set forth in Section 9.02.

1.12 "Code" has the meaning set forth in Sections 3.07.

1.13 "Confidentiality Agreement" has the meaning set forth in Section 5.04.

1.14 “COPA Acts” has the meaning set forth in Section 5.06(a).

1.15 “Effective Date” has the meaning set forth in Section 5.01.

1.16 "Effective Time" has the meaning set forth in Section 5.01.

1.17 "ERISA" has the meaning set forth in Sections 3.16(b) and 4.16(b).

1.17 “Expenses” has the meaning set forth in Section 10.04.

1.18 “Event of Default” has the meaning given it in the Master Indenture.

1.19 "Federal health care programs" has the meaning set forth in Sections 3.17(g) and 4.17(g).

1.20 "Financial Statements" has the meaning set forth in Sections 3.04 and 4.04.

1.21 "GAAP" has the meaning set forth in Sections 3.04.

1.22 "Government Programs" has the meaning set forth in Sections 3.17(b) and 4.17(b).

1.23 "Governmental Entity" has the meaning set forth in Section 3.17(a)(i) and 4.17(b)(i).

1.24 "Hazardous Substances" has the meaning set forth in Sections 3.14(b) and 4.14(b).

1.25 "HSR" has the meaning set forth in Section 5.05.

1.26 "Improvements" has the meaning set forth in Section 3.13(c) and 4.13(c).

1.27 “Initial Management Team” has the meaning set forth in Section 2.01(f).

1.28 “Interested Person” means with respect to any individual serving on or otherwise eligible to serve on the Parent Company Board of Directors, any committee of the Parent Company Board of Directors, the Board of Directors or any Board committee of MSHA, Wellmont, and any of their subsidiaries, that such individual fits within the published guidance issued by the Exempt Organizations Division of the Internal Revenue Service of the United States of America (the IRS EO Division) regarding which individuals are considered interested persons with respect to 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.

1.29 "Intermediate Sanctions" has the meaning set forth in Sections 3.08(i) and 4.08(i).

1.30 “Knowledge of MSHA” has the meaning set forth in Section 4.07.

1.31 "Knowledge of Wellmont" has the meaning set forth in Section 3.07.

1.32 "Leased Real Property" has the meaning set forth in Sections 3.13(b) and 4.13(b).

1.33 “Master Indenture” means the Amended and Restated Master Trust Indenture, dated as of February 1, 2000, as supplemented by the Thirty-Ninth Supplemental Master Indenture dated as of July 1, 2013 between MSHA and The Bank of New York Mellon Trust Company, as Master Trustee.

1.34 "Material Adverse Effect" means, with respect to any Party, any event, circumstance, development, condition, occurrence, state of facts, change or effect that is or is reasonably likely to have (i) a material adverse effect on the business, assets, results of operations or financial condition of such Party and its Subsidiaries, taken as a whole or (ii) a material adverse effect on the ability of such Party to consummate the transactions contemplated by this Agreement in either case, other than any event, circumstance, development, condition, occurrence, state of facts, change or effect resulting from any one or more of the following: (A) any change in the United States or foreign economies or securities or financial markets in general; (B) any change that affects any industry in which such Party operates; (C) any change arising in connection with natural disasters or acts of nature, hostilities, acts of war, sabotage or terrorism or military actions or any escalation or material worsening of any such hostilities, acts of war, sabotage or

terrorism or military actions existing or underway as of the date hereof; (D) any action taken by the other Party to this Agreement with respect to the transactions contemplated by this Agreement; (E) any changes in applicable Laws, accounting rules or the interpretation thereof; (F) the failure of such Party to meet any projections; (G) compliance by such Party with the terms of, or taking any action required by, this Agreement; (H) actions required to be taken by such Party under applicable law or contracts; or (I) the public announcement of this Agreement or the consummation of the transactions contemplated by this Agreement.

1.35 "Medicaid" has the meaning set forth in Sections 3.17(b) and 4.17(b).

1.36 "Medicare" has the meaning set forth in Sections 3.17(b) and 4.17(b).

1.37 "MSHA" has the meaning set forth in the Recitals.

1.38 "MSHA Financial Statements" has the meaning set forth in Section 4.08.

1.39 "MSHA Facility" and "MSHA Facilities" have the meaning set forth in Section 4.17(b).

1.40 “MSHA Material Contract” has the meaning set forth in Section 4.07.

1.41 "MSHA Subsidiary" and "MSHA Subsidiaries" have the meaning set forth in Section 4.03.

1.42 “Notes” means the Mountain States Health Alliance Notes Series 2013A, Series 2013B, Series 2013C, Series 2013D, Series 2013E, Series 2013F, Series 2013G, Series 2013H issued pursuant to the Master Indenture.

1.43 “Outside Date” has the meaning set forth in Section 8.01(b).

1.44 "Owned Real Property" has the meaning set forth in Sections 3.13(a) and 4.13(a).

1.45 “Parent Company” has the meaning set forth in Section 1.02(a).

1.46 “Parent Company Articles” has the meaning set forth in Section 2.01(a).

1.47 “Parent Company Bylaws” has the meaning set forth in Section 2.01(a).

1.48 "Party" and "Parties" have the meaning set forth in the Recitals.

1.49 "Permitted Liens" has the meaning set forth in Sections 3.09 and 4.09.

1.50 "Person" has the meaning set forth in Sections 3.17(a)(ii) and 4.17(a)(ii0.

1.51 "Plans" has the meaning set forth in Sections 3.16(b) and 4.16(b).

1.52 "Prior Representation" has the meaning set forth in Section 5.07.

1.53 "Proper Court" has the meaning set forth in Section 10.05(b).

1.54 "Qualified Plan" has the meaning set forth in Sections 3.16(e) and 4.16(e).

1.55 "Real Property Leases" has the meaning set forth in Sections 3.13(b) and 4.13(b).

1.56 "Tax" and "Taxes" have the meaning set forth in Sections 3.08(a) and 4.08(a).

1.57 "Tax-Exempt Wellmont Subsidiaries" has the meaning set forth in Section 3.08(i).

1.58 “Tax Exempt MSHA Subsidiaries” has the meaning set forth in Section 4.08(i).

1.59 "Tax Return" has the meaning set forth in Sections 3.08(b) and 4.08(b).

1.60 “Tennessee COPA Act” has the meaning set forth in Section 5.06(a).

1.61 “Virginia COPA Act” has the meaning set forth in Section 5.06(a).

1.62 "Wellmont" has the meaning set forth in the Recitals.

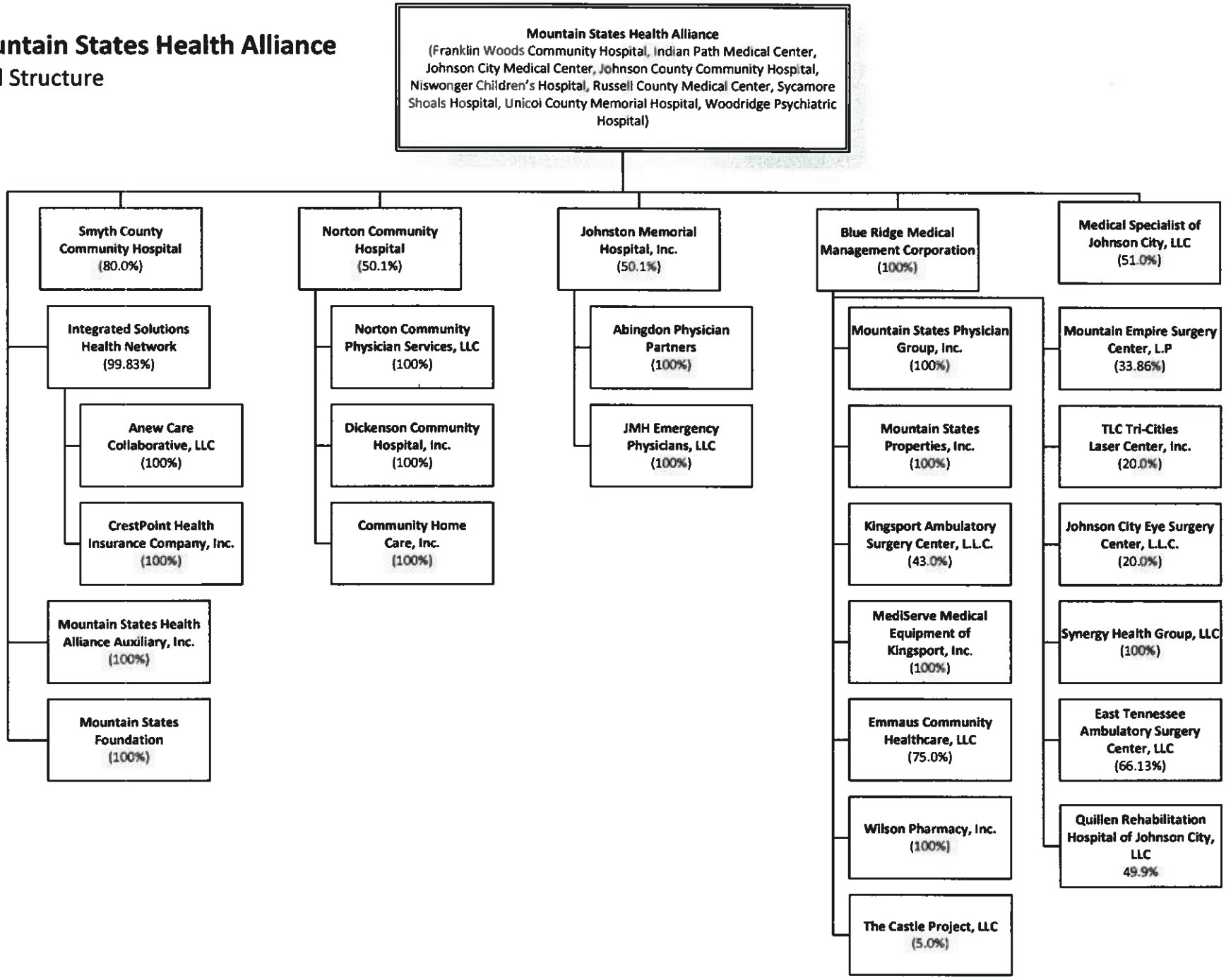
1.63 "Wellmont Facility" and "Wellmont Facilities" have the meaning set forth in Section 3.17(b).

1.64 “Wellmont Material Contract has the meaning set forth in Section 3.07.

1.65 "Wellmont Subsidiary" and "Wellmont Subsidiaries" have the meaning set forth in Section 3.03.

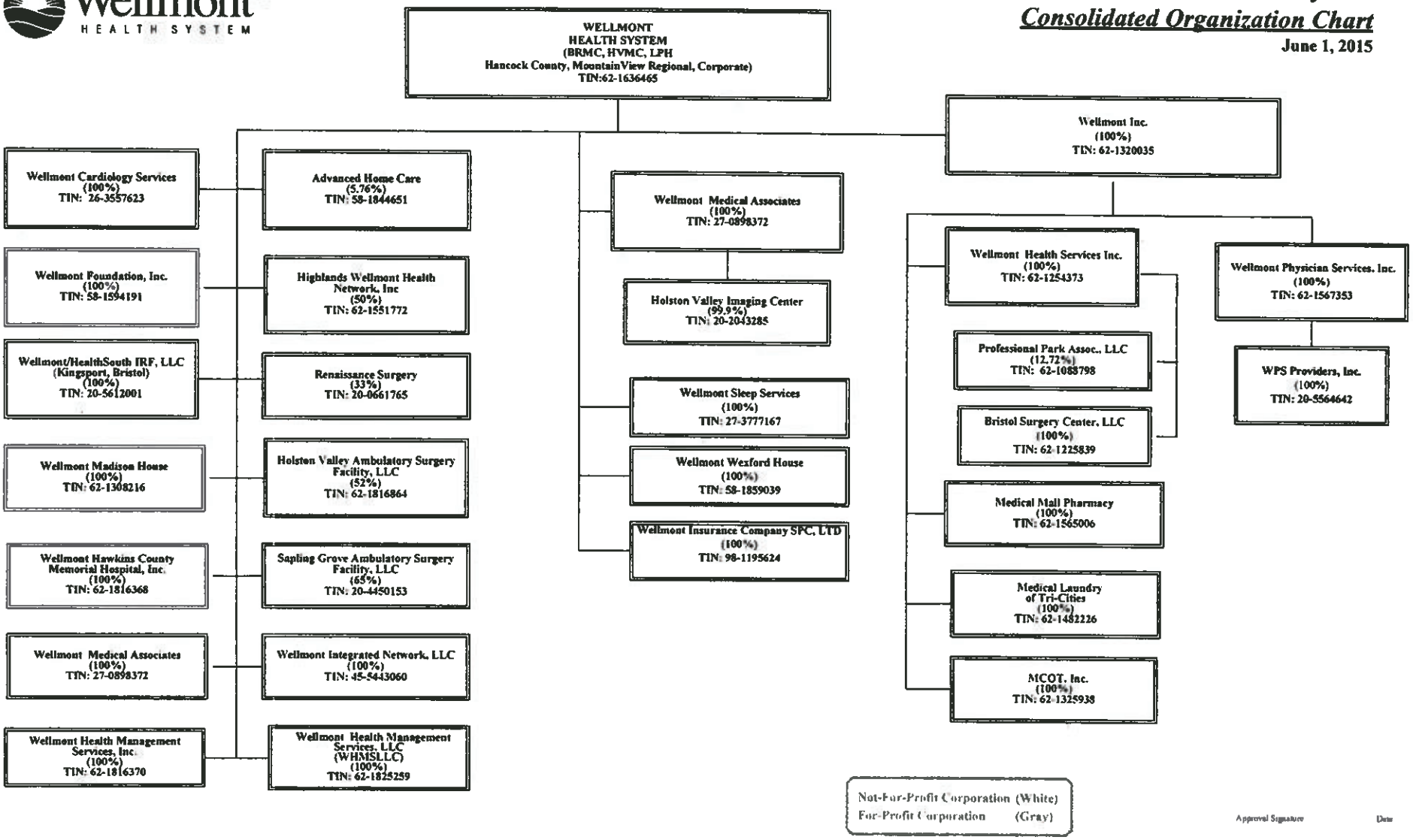
Mountain States Health Alliance

Legal Structure



Wellmont HEALTH SYSTEM

Wellmont Health System
Consolidated Organization Chart
June 1, 2015



MSHA0586

ATTACHMENT E

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part V Compensation and Other Financial Arrangements with your Officers, Directors, Trustees, Employees and Independent Contractors.

1a List the names, titles, and mailing addresses of all of your officers, directors, and trustees. For each person listed, state their total annual compensation, or proposed compensation, for all services to the organization, whether as an officer, employee, or other position. Use actual figures, if available. Enter "none" if no compensation is or will be paid. If additional space is needed, attach a separate sheet. Refer to the instructions for information on what to include as compensation.

Names of Officers and Directors	Address	Title
Community Directors		
Barbara Allen	301 Med Tech Pkwy Johnson City, TN 37604	Director
Gary Peacock	301 Med Tech Pkwy Johnson City, TN 37604	Director
Roger Leonard	1905 American Way, Kingsport, TN 37660	Director
Roger K. Mowen, Jr.	1905 American Way, Kingsport, TN 37660	Director
Officers		
Bart Hove	1905 American Way, Kingsport, TN 37660	Chief Executive Officer
Alice H. Pope	1905 American Way, Kingsport, TN 37660	Chief Financial Officer
Marvin Eichorn	301 Med Tech Pkwy Johnson City, TN 37604	Chief Operating Officer
Alan Levine	301 Med Tech Pkwy Johnson City, TN 37604	Executive Chair/President

1.a. The directors of Applicant receive no compensation for fulfilling their duties as directors, but may receive reimbursement of expenses for attending Board meetings under the Bylaws. Below is a summary of compensation packages for the officers of the Applicant.

Bart Hove:

Base salary: not less than $800,000*

Alice H. Pope:

Base salary: not less than $410,000*

Marvin Eichorn

Base salary:$555,000*

Alan Levine

Base salary:$925,000*

*The compensation packages for the Applicant's executives are currently being negotiated. The base salaries are expected to be not less than the current salaries paid to the executives by each executive's current employer (Wellmont or MSHA, as applicable). In addition to the amounts set forth above, the Applicant expects the compensation packages to include other benefits, which benefits may include severance pay, change of control payments, automobile allowance, performance bonuses, retirement plans, and split-dollar life insurance arrangements. All compensation arrangements will be submitted for review and approval by the Applicant's board, in accordance with its bylaws and conflict of interest policy, and will be limited to reasonable compensation as determined based on third party appraisals or comparable data.

1.b. Applicant contemplates having no employees, other than the officers listed above, making more than $50,000 per year.

1.c. Applicant contemplates having no independent contractors receiving payments of more than $50,000 year.

3.a. For each of your officers, directors, trustees, highest compensated employees and highest compensated independent contractors listed above, attached a list showing name, qualifications, average hours worked and duties:

Name	Qualifications	Average Hours Worked	Duties
Directors			
Barbara Allen	* See below	4 hrs per week for the Applicant	Oversight , transition and strategic direction in her capacity as Director of the Applicant
Gary Peacock	* See below	4 hrs per week for the Applicant	Oversight , transition and strategic direction in his capacity as Director of the Applicant
Roger Leonard	* See below	4 hrs per week for the Applicant	Oversight , transition and strategic direction in his capacity as Director of the Applicant
Roger K. Mowen, Jr.	* See below	4 hrs per week for the Applicant	Oversight , transition and strategic direction in his capacity as Director of the Applicant
Officers			
Alice H. Pope	Currently an executive for Wellmont	40 hrs per week for the Applicant	Oversight , transition and strategic direction in her capacity as an officer of the Applicant
Bart Hove	Currently an executive for Wellmont	40 hrs per week for the Applicant	Oversight , transition and strategic direction in his capacity as officer of the Applicant
Marvin Eichorn	Currently an executive for MSHA	40 hrs per week for the Applicant	Oversight , transition and strategic direction in his capacity as officer of the Applicant
Alan Levine	Currently an executive	40 hrs per week for the	Oversight , transition and strategic direction

	for MSHA	Applicant	in his capacity as officer of the Applicant

* **Barbara Allen.**

Bristol native Barbara Allen has been operations/general manager since 1994 of Stowaway Storage, a family-owned small business in Johnson City, Tenn., where she operates storage warehouse sites throughout Northeast Tennessee.

She graduated from East Tennessee State University with a BBA in accounting in 1983, and then was employed as a systems engineer and communications marketing specialist with IBM in Kingsport until 1994.

Barbara was fundraising chairman during the building of the Ronald McDonald House and served on the organization's board of directors from its inception until 1997. She also chaired the board of directors at Appalachian Christian Camp. In addition to currently serving as the Chair of the Mountain States Health Alliance (MSHA) Board of Directors, she has served on the board of directors for various other MSHA entities as well, including Washington County facilities (chair) and Blue Ridge Medical Management and also on Johnston Memorial Hospital board of trustees. On the Mountain States corporate board she has been a member of the committees for Audit and Compliance; Quality; Finance; Social Responsibility; and Corporate Membership.

In 2002 she received Milligan College Leader in Christian Service Award and in 2006 was the recipient of East Tennessee State University College of Business and Technology's Horizon Award.

***Gary Peacock**

Gary retired as senior vice president of operations for Royal Mouldings (previously Marley Mouldings) where he supervised approximately 700 employees and enjoyed a 41-year career with the company. He and his wife own The Glass Peacock in Abingdon, VA and The Wood Peacock in Marion, VA.

He has served as chair of the Smyth County Community Hospital board of directors. He has served as Chair of the Board of Directors, as well as vice chair and chair of the PI committee.

He has been an active member of the Smyth County Chamber of Commerce and in various educational initiatives, including serving on the subcommittee of the hospital to research and build the Wellness Center.

He holds a bachelor's degree in education with a minor in arts and architecture from Oregon State University.

* **Roger Leonard** combines extensive business experience, a diverse academic background and lifelong ties to the Tri-Cities to give him special insight into the needs of Wellmont Health System patients and medical professionals.

A Wellmont board member since 2009, Leonard is now the panel's chairman as well as a member of the Joint Board Task Force, which was formed as part of the proposed merger of Wellmont and Mountain States Health Alliance. He has previously chaired Wellmont's audit and compliance and investment committees.

Leonard, a respected community leader, is a senior adviser for England & Co., a national boutique investment bank that concentrates on supporting the growth of middle market companies. Earlier in his career, he served as president and chief operating officer of Electro-Mechanical Corp. in Bristol, Virginia. Leonard has been an adjunct faculty member at King University, teaching corporate finance and operations management.

He has also been a community servant throughout the region, lending his expertise to a variety of community organizations. He has served as chairman of the boards for the United Way of Bristol, Tennessee/Virginia; the Bristol Public Library and Foundation; Crossroads Medical Mission in Bristol, Virginia; and Hands On! Children's Museum in Johnson City.

After receiving a bachelor's degree in operations management from the University of Tennessee, Leonard obtained a master of business administration from Wake Forest University and a master of theological studies from Duke Divinity School. He also completed the program for management development at Harvard Business School.

* **Roger K. Mowen Jr.**'s distinguished career with one of the region's most respected companies is adding another dimension of business acumen to the Wellmont Health System board of directors.

Mowen completed his 34-year career at Eastman Chemical Company, which is a member of the Fortune 500, as senior vice president of global developing businesses and corporate strategy. He was also responsible for information technology.

He joined Eastman in 1971, and his three decades with the company included service as president of Carolina operations, vice president and general manager of polymer modifiers, vice president of customer demand chain, vice president of CustomerFirst and chief information officer. During his tenure there, he led efforts to establish an executive master's in business administration program for high-potential employees.

Steeped in community affairs, Mowen served as chairman of Wellmont's board from 2008-10 and has also sat as a member of the Holston Valley Medical Center board. In addition, Mowen has been board chairman for Contact-Concern of Northeast Tennessee, Friends in Need and the Greater Kingsport YMCA. He is chairman of Healthy Kingsport, a community advisory committee for the Kingsport Board of Mayor and Aldermen; a member of the YMCA board; and a member of the Kingsport Kiwanis Club.

Mowen has a bachelor's degree in textile chemistry from Philadelphia University and a master's degree in textile technology from North Carolina State University.

ATTACHMENT F

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part V: *Compensation and Other Financial Arrangements with your Officers, Directors, Trustees, Employees and Independent Contractors.*

5.a. Have you adopted **a conflict of interest policy** consistent with the sample conflict of interest policy in Appendix A to the instructions? If "Yes," provide a copy of the policy and explain how the policy has been adopted, such as by resolution of your governing board. If "No," answer lines 5b and 5c.

Yes. Attached is a copy of the Applicant's Conflict of Interest Policy which reflects the IRS Revised Model Conflicts of Interest Policy. The policy was adopted by the resolution of the Applicant's Board of Directors.

NEWCO, INC.
CONFLICT OF INTEREST POLICY

Article I
Purpose

The purpose of the conflict of interest policy is to protect the interest of Newco, Inc. (the "Corporation") when it is contemplating a transaction or arrangement that (a) might benefit the private interest of an officer or director of the Corporation, (b) might benefit another healthcare system in which an officer or director of the Corporation serves as an officer, director or manager (other than the healthcare system which directly employs such officer or director), or (c) might result in a possible excess benefit transaction. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Article II
Definitions

1. Interested Person

Any director, principal officer, or member of a committee with governing board delegated powers, who has a direct or indirect financial, personal, or positional interest, as defined below, is an interested person. If a person is an interested person with respect to any entity in the health care system of which the Corporation is a part, he or she is an interested person with respect to all entities in the health care system.

2. Financial, Personal, or Positional Interest

A person has a financial, personal or positional interest if the person, directly or indirectly, through business, investment, or family:

a. Has ownership or investment interest in any entity with which the Corporation has a transaction or arrangement,

b. Has compensation arrangement with the Corporation or with any entity or individual with which the Corporation has a transaction or arrangement,

c. Has potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Corporation is negotiating a transaction or arrangement; or

d. Serves as a director, officer or manager of a healthcare system (other than the healthcare system which directly employees such person) which provides services that are similar to or competitive with those services that are non-exclusive services provided by the Corporation.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial, personal, or positional interest is not necessarily a conflict of interest. Under Article Ill, Section 2, a person who has a financial, personal, or positional interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Article III
Procedures

1. Duty to Disclose

In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial, personal, or positional interest and be given the opportunity to disclose all material facts to the directors and members of committees with governing board delegated powers considering the proposed transaction or arrangement.

2. Determining Whether a Conflict of Interest Exists

After disclosure of the financial, personal, or positional interest and all material facts, and after any discussion with the interested person, he/she shall leave the governing board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

3. Procedures for Addressing the Conflict of Interest

a. An interested person may make a presentation at the governing board or committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.

b. The chairperson of the governing board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

c. After exercising due diligence, the governing board or committee shall determine whether the Corporation can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the Corporation's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement,

4. Violations of the Conflicts of Interest Policy

a. If the governing board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflicts of interest, it shall inform the member of the basis

for such belief and afford the member an opportunity to explain the alleged failure to disclose.

b. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Article IV
Records of Proceedings

The minutes of the governing board and all committees with board delegated powers shall contain:

a. The names of the persons who disclosed or otherwise were found to have a financial, personal, or positional interest in connection with an actual or possible conflict of interest, the nature of the financial, personal, or positional interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed,

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings,

Article V
Compensation

a. A voting member of the governing board who receives compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation,

b. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Corporation for services is precluded from voting on matters pertaining to that member's compensation**.**

c. No voting member of the governing board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Corporation, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

d. Physicians who receive compensation from the Corporation, whether directly or indirectly or as employees or independent contractors, are precluded from membership on any committee whose jurisdiction includes compensation matters. No physician, either individually or collectively, is prohibited from providing information to any committee regarding physician compensation.

Article VI
Annual Statements

Each director, principal officer and member of a committee with governing board delegated powers shall annually sign a statement which affirms such person:

a. Has received a copy of the conflicts of interest policy,

b. Has read and understands the policy,

c. Has agreed to comply with the policy, and

d. Understands the Corporation is charitable and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

Article VII
Periodic Reviews

To ensure the Corporation operates in a manner consistent with charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

a. Whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's length bargaining.

b. Whether partnerships, joint ventures, and arrangements with management organizations conform to the Corporation's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

Article VIII
Use of Outside Experts

When conducting the periodic reviews as provided for in Article VII, the Corporation may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

ATTACHMENT G

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part V: *Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors*

6.a Do you or will you compensate any of your officers, directors, trustees, highest compensated employees, and highest compensated independent contractors listed in lines 1a, 1b, or 1c through non-fixed payments, such as discretionary bonuses or revenue-based payments? If "Yes," describe all non-fixed compensation arrangements, including how the amounts are determined, who is eligible for such arrangements, whether you place a limitation on total compensation, and how you determine or will determine that you pay no more than reasonable compensation for services. Refer to the instructions for Part V, lines 1a, 1b, and 1c, for information on what to include as compensation.

The Applicant expects a portion of its executives' salaries to be earned only if certain performance standards are achieved. The standards will be established by the Applicant's board and will include objective and subjective criteria. Such portion of the salary, when combined with other compensation and benefits, will not exceed a reasonable compensation for the services rendered, as determined by using third party valuation experts or comparable compensation data.

Additionally, the Applicant expects it will sponsor a secured executive benefit program for certain key executives, pursuant to which it will contribute annual amounts necessary to produce a target benefit for the participants at their retirement date, although no benefit level is guaranteed. Additionally, the Applicant expects to sponsor a Section 457(f) plan for certain key executives. The availability of any such plans will only be made in accordance with the Applicant's approved compensation policy and in a manner to provide that total compensation paid to its executives is reasonable.

The Applicant expects its senior executives will qualify for certain non-fixed compensation arrangements. The Applicant will establish and periodically monitor compensation of its executives by third party appraisals and internal comparable compensation analysis to ensure all compensation paid is reasonable and within the range of fair market value.

6.b Do you or will you compensate any of your employees, other than your officers, directors, trustees, or your five highest compensated employees who receive or will receive compensation of more than $50,000 per year, through non-fixed payments, such as discretionary bonuses or revenue-based payments? If "Yes," describe all non-fixed compensation arrangements, including how the amounts are or will be determined, who is or will be eligible for such arrangements, whether you place or will place a limitation on total compensation, and

how you determine or will determine that you pay no more than reasonable compensation for services. Refer to the instructions for Part V, lines 1a, 1b,and 1c, for information on what to include as compensation.

Applicant may have employees in addition to the officers identified in Part V above who will be eligible to participate in the Section 457(f) plan and who may qualify for certain non-fixed compensation arrangements, as described above.

ATTACHMENT H

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part V: *Compensation and Other Financial Arrangements With Your Officers, Directors, Trustees, Employees, and Independent Contractors*

9.a. Do you or will you have any leases, contracts, loans, or other arrangements with any organization in which any of your officers, directors, or trustees are also officers, directors, or trustees, or in which any individual officer, director, or trustee owns more than a 35% interest? If "Yes," provide the information requested in lines 9b through 9f.

As a supporting organization for MSHA and Wellmont, the Applicant expects to have contracts and other arrangements with those supported organizations. Certain of the directors and officers of the Applicant and MSHA are also directors and officers of the Applicant. Any such contracts or arrangements will be approved in accordance with the Applicant's conflicts of interest policy and will support the purpose of the Applicant and its supported organizations. The Applicant does not expect to have any leases, contracts, loans, or other arrangements with any organization in which any of the Applicant's officers, directors, or trustees are also officers, directors, or trustees, or in which any individual officer, director, or trustee owns more than a 35% interest, other than organizations for which the Applicant is a supporting organization.

ATTACHMENT I

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part VI: *Your Members and Other Individuals and Organizations That Receive Benefits From You.*

1.b. In carrying out your exempt purposes, do you provide goods, services, or funds to organizations? If "Yes," describe each program that provides goods, services, or funds to organizations..

As a supporting organization for MSHA and Wellmont, the Applicant expects to provide services and funds to those supported organizations. All such services and funds will be in furtherance of the Applicant's exempt purpose.

ATTACHMENT J

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part VIII: *Your Specific Activities.*

2a Do you attempt to influence legislation? If "Yes," explain how you attempt to influence legislation and complete line 2b. If "No," go to line 3a.

The applicant expects that it will engage in a limited amount of activities to influence legislation related to its exempt purpose. Any such effort will be an insubstantial amount of the Applicant's activities based on time and expense. Wellmont and MSHA, the organizations supported by the Applicant, have historically engaged in a limited amount of lobbying as permitted under applicable regulations. Those activities include involvement in industry groups who lobby for its members and direct lobbying efforts and expenditures for issues related to their health care operations, such as certificate of need laws, Medicaid expansion, graduate medical education and trauma care funding. MSHA currently has a community and government relations vice president responsible for lobbying efforts and expenditures. Wellmont also employs a vice president of government relations responsible for lobbying efforts and expenditures. The lobbying activity for Wellmont and MSHA have been reported on their respective Forms 990. Those efforts may be consolidated and provided through the Applicant, but in any event will be limited to an insubstantial portion of the Applicant's total activities.

2b Have you made or are you making an election to have your legislative activities measured by expenditures by filing Form 5768? If "Yes," attach a copy of the Form 5768 that was already filed or attach a completed Form 5768 that you are filing with this application. If "No," describe whether your attempts to influence legislation are a substantial part of your activities. Include the time and money spent on your attempts to influence legislation as compared to your total activities.

At this point a decision has not been made to file an election under Section 501(h). However, the Applicant's board may decide in the future to file the election. The Applicant does not currently have a specific agenda for its lobbying efforts or a budget for any lobbying efforts. However, recent lobbying expenditures for Wellmont and MSHA offer a guide to the amount of expenditures that may be incurred if the supported organizations' lobbying efforts are consolidated and provided through the Applicant. As reported on its Form 990, for the fiscal year ended June 30, 2014, Wellmont (which has a Section 501(h) election in place) had $169,101 in lobbying expenditures on $653,391,732 total exempt purpose expenditures. As reported on its Form 990, for the fiscal year ended June 30, 2013, MSHA (which does not have a Section 501(h)

election in place) had $250,140 in lobbying expenditures on $682,303,738 total exempt purpose expenditures.

ATTACHMENT K

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part VIII: *Your Specific Activities.*

13.b. Describe how your grants, loans, or other distributions to organizations further your exempt purposes.

Applicant expects to contribute substantially all of its total annual income to support MSHA and Wellmont. In addition, Applicant will use its income to perform the functions of, and to carry out the purposes of MSHA and Wellmont. Any amounts retained by Applicant would be retained to improve the operations of MSHA and Wellmont. Applicant's purposes to promote health care services in Tennessee and Virginia and Applicant's activities are those which the MSHA System and Wellmont, has established and historically supported. It is anticipated that Applicant will from time to time provide charitable donations, grants and support to MSHA and Wellmont in furtherance of Applicant's charitable purpose to further health care services in the community, and in compliance with its status as an IRC § 509(a)(3) supporting organization for MSHA and Wellmont. Applicant will keep records of such support. There is no selection process, since Applicant is required to support MSHA and Wellmont as part of its qualification as a supporting organization. Since Applicant is an affiliate of MSHA and Wellmont, it is not anticipated that Applicant will require periodic and final reports on the use of resources.

*13.d. Identify each recipient organization and any **relationship** between you and the recipient organization.*

The Applicant is or will become the sole member of MSHA and Wellmont, which will collectively receive substantially all of Applicant's total annual income.

ATTACHMENT L

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part VIII: *Your Specific Activities*

15. Do you have a close connection with any organizations? If "Yes," explain.

The applicant has or will have a "close connection" with MSHA and Wellmont by virtue of the Applicant being or becoming the sole member of MSHA and Wellmont.

ATTACHMENT M

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Part IX: *Financial Data*

Please find attached pro forma budgeted revenues and expenses for the current year and the succeeding 2 years for the Applicant and a balance sheet dated June 30, 2016 for the Applicant.

Part IX Financial Data
(in '000's)

A. Statement of Revenues and Expenses

Type of revenue or expense	From 9/11/15 - 6/30/16	From 7/1/16 - 6/30/17	From 7/1/17 - 6/30/18		Total
Management Fee Revenue	$ 3,730	$ 3,830	$ 3,930		$ 11,490
Operating Expenses :					
Salaries Wages, Benefits	$ 3,330	$ 3,430	$ 3,530		$ 10,290
Other	$ 400	$ 400	$ 400		$ 1,200
Total Expenses	$ (3,730)	$ (3,830)	$ (3,930)		$ (11,490)
Net Income	$ -	$ -	$ -	#	$ -

B. Balance Sheet	**Year end: 6/30/16**
Assets	
Cash	$ 100
Other Assets	$ -
Total Assets	$ 100
Liabilities	$ -
Net Assets	$ 100

ATTACHMENT N

SUPPLEMENT TO FORM 1023,
APPLICATION FOR RECOGNITION OF EXEMPTION

Filed on Behalf of

Newco, Inc.
EIN: 61-1771290

Schedule D.

Section I. *Identifying Information About the Supported Organization(s)*

1 *State the names, addresses, and EINs of the supported organizations.*

Name	Address	EIN
Wellmont Health System	1905 American Way Kingsport, TN 37660	62-1636465
Mountain States Health Alliance	301 Med Tech Pkwy Johnson City, TN 37604	62-0476282

Section II. *Relationship With Supported Organization(s) – Three Tests*

2 *Information to establish the "Supervised or controlled in connection with" relationship (Test 2)*

Does a majority of your governing board consist of individuals who also serve on the governing board of the supported organization(s)? If "Yes," describe the process by which your governing board is appointed and elections; go to Section III. If "No," continue to line 3.

Applicant intends to be a supporting organization as described in Code Section 509(a)(3), supervised and controlled in connection with MSHA and Wellmont, organizations described in Code Sections 509(a)(1) and 170(b)(1)(A)(iii). Specifically, Applicant will be a Type II supporting organization described in Code Section 509(a)(3)(B)(ii). Applicant's Articles of Incorporation and Bylaws explicitly describe this relationship.

Pursuant to Article III, Section 2 of Applicant's initial Bylaws, the Board of Directors of Applicant shall consist of four (4) directors, two (2) of whom shall be appointed by MSHA and two (2) of whom shall be appointed by Wellmont. The two (2) directors appointed by MSHA will also be directors of MSHA. The two (2) directors appointed by Wellmont will also be directors of Wellmont.

After the amended and restated Bylaws are adopted, the Applicant's Board of Directors will be comprised of fourteen (14) voting members, as well as two (2) ex-officio voting members and one (1) ex-officio non-voting member. MSHA and Wellmont will each designate six (6)

members to serve on the board of the Applicant, and MSHA and Wellmont will jointly select two (2) members of the Applicant's Board of Directors. The two ex-officio voting members will be the Applicant's Executive Chairman/President and the Applicant's Chief Executive Officer. The ex-officio non-voting member will be the then current President of East Tennessee State University. As provided in Article III, Section 1(j) of the amended and restated Bylaws, at all times the Applicant's Board of Directors will consist of the same individuals who are serving on the Boards of Directors of MSHA and Wellmont. In other words, Applicant, MSHA, and Wellmont will have identical Boards of Directors at all times, and the Bylaws of MSHA and Wellmont will be amended to provide for this commonality. These amendments will be effective upon Closing of the transaction establishing Applicant as the sole member of MSHA and of Wellmont.

Two years after the integration of MSHA and Wellmont (i.e., "Post-Integration"), the Board of Directors of Applicant will remain the same except that the individual serving as Executive Chair/President of Applicant will no longer be an ex-officio director, and that vacancy will be filled by the remaining directors who were originally appointed by Wellmont. However, the Board of Directors of Applicant, MSHA, and Wellmont will continue to be identical. Therefore, at all times Applicant will be supervised and controlled in connection with MSHA and Wellmont, as described in Code Section 509(a)(3)(B)(ii).

Form **2848**
(Rev. July 2014)
Department of the Treasury
Internal Revenue Service

Power of Attorney and Declaration of Representative

▶ **Information about Form 2848 and its instructions is at *www.irs.gov/form2848.***

OMB No. 1545-0150

For IRS Use Only
Received by:
Name
Telephone
Function
Date / /

Part I Power of Attorney

Caution: *A separate Form 2848 must be completed for each taxpayer. Form 2848 will not be honored for any purpose other than representation before the IRS.*

1 Taxpayer information. Taxpayer must sign and date this form on page 2, line 7.

Taxpayer name and address	Taxpayer identification number(s)	
Newco, Inc. **211 Commerce St.** **Nashville, TN 37201-1817**	**61-1771290**	
	Daytime telephone number	Plan number (if applicable)

hereby appoints the following representative(s) as attorney(s)-in-fact:

2 Representative(s) must sign and date this form on page 2, Part II.

Name and address	CAF No. / PTIN / Telephone No. / Fax No. / Check if new
John B. Beard **Baker, Donelson, Bearman, Caldwell & Berkowitz, PC** **PO Box 14167, Jackson, MS 39236** **Check if to be sent copies of notices and communications** ☐	CAF No. **5005-45062R** PTIN Telephone No. **601-351-2498** Fax No. **601-592-7498** Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. / PTIN / Telephone No. / Fax No. / Check if new
Jon D. Seawright **Baker, Donelson, Bearman, Caldwell & Berkowitz, PC** **PO Box 14167, Jackson, MS 39236** **Check if to be sent copies of notices and communications** ☐	CAF No. **0301-96877R** PTIN Telephone No. **601-351-8921** Fax No. **601-974-8921** Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address (**Note.** IRS sends notices and communications to only two representatives.)	CAF No. / PTIN / Telephone No. / Fax No. / Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address (**Note.** IRS sends notices and communications to only two representatives.)	CAF No. / PTIN / Telephone No. / Fax No. / Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

to represent the taxpayer before the Internal Revenue Service and perform the following acts:

3 Acts authorized (you are required to complete this line 3). With the exception of the acts described in line 5b, I authorize my representative(s) to receive and inspect my confidential tax information and to perform acts that I can perform with respect to the tax matters described below. For example, my representative(s) shall have the authority to sign any agreements, consents, or similar documents (see instructions for line 5a for authorizing a representative to sign a return).

Description of Matter (Income, Employment, Payroll, Excise, Estate, Gift, Whistleblower, Practitioner Discipline, PLR, FOIA, Civil Penalty, Sec. 5000A Shared Responsibility Payment, Sec. 4980H Shared Responsibility Payment, etc.) (see instructions)	Tax Form Number (1040, 941, 720, etc.) (if applicable)	Year(s) or Period(s) (if applicable) (see instructions)
Exemption from Federal Income Tax	**1023**	**N/A**

4 Specific use not recorded on Centralized Authorization File (CAF). If the power of attorney is for a specific use not recorded on CAF, check this box. See the instructions for **Line 4. Specific Use Not Recorded on CAF** . . . . . ▶ ☐

5a Additional acts authorized. In addition to the acts listed on line 3 above, I authorize my representative(s) to perform the following acts (see instructions for line 5a for more information):

☐ Authorize disclosure to third parties; ☐ Substitute or add representative(s); ☐ Sign a return; _____

☐ Other acts authorized: _____

b **Specific acts not authorized.** My representative(s) is (are) not authorized to endorse or otherwise negotiate any check (including directing or accepting payment by any means, electronic or otherwise, into an account owned or controlled by the representative(s) or any firm or other entity with whom the representative(s) is (are) associated) issued by the government in respect of a federal tax liability.
List any specific deletions to the acts otherwise authorized in this power of attorney (see instructions for line 5b): _____

6 **Retention/revocation of prior power(s) of attorney.** The filing of this power of attorney automatically revokes all earlier power(s) of attorney on file with the Internal Revenue Service for the same matters and years or periods covered by this document. If you **do not** want to revoke a prior power of attorney, check here . . . . . ▶ ☐
YOU MUST ATTACH A COPY OF ANY POWER OF ATTORNEY YOU WANT TO REMAIN IN EFFECT.

7 **Signature of taxpayer.** If a tax matter concerns a year in which a joint return was filed, each spouse must file a separate power of attorney even if they are appointing the same representative(s). If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.
▶ **IF NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THIS POWER OF ATTORNEY TO THE TAXPAYER.**

Signature	Date	Title (if applicable)
Alan M Levine	3/5/16	~~Alan M. Levine~~ President
Alan M. Levine		
Print Name	Print name of taxpayer from line 1 if other than individual	

Part II Declaration of Representative

Under penalties of perjury, by my signature below I declare that:

- I am not currently suspended or disbarred from practice before the Internal Revenue Service;
- I am subject to regulations contained in Circular 230 (31 CFR, Subtitle A, Part 10), as amended, governing practice before the Internal Revenue Service;
- I am authorized to represent the taxpayer identified in Part I for the matter(s) specified there; and
- I am one of the following:

a Attorney—a member in good standing of the bar of the highest court of the jurisdiction shown below.
b Certified Public Accountant—duly qualified to practice as a certified public accountant in the jurisdiction shown below.
c Enrolled Agent—enrolled as an agent by the Internal Revenue Service per the requirements of Circular 230.
d Officer—a bona fide officer of the taxpayer organization.
e Full-Time Employee—a full-time employee of the taxpayer.
f Family Member—a member of the taxpayer's immediate family (for example, spouse, parent, child, grandparent, grandchild, step-parent, step-child, brother, or sister).
g Enrolled Actuary—enrolled as an actuary by the Joint Board for the Enrollment of Actuaries under 29 U.S.C. 1242 (the authority to practice before the Internal Revenue Service is limited by section 10.3(d) of Circular 230).
h Unenrolled Return Preparer—Your authority to practice before the Internal Revenue Service is limited. You must have been eligible to sign the return under examination and have prepared and signed the return. **See Notice 2011-6 and *Special rules for registered tax return preparers and unenrolled return preparers* in the instructions (PTIN required for designation h).**
i Registered Tax Return Preparer—registered as a tax return preparer under the requirements of section 10.4 of Circular 230. Your authority to practice before the Internal Revenue Service is limited. You must have been eligible to sign the return under examination and have prepared and signed the return. **See Notice 2011-6 and *Special rules for registered tax return preparers and unenrolled return preparers* in the instructions (PTIN required for designation i).**
k Student Attorney or CPA—receives permission to represent taxpayers before the IRS by virtue of his/her status as a law, business, or accounting student working in an LITC or STCP. See instructions for Part II for additional information and requirements.
r Enrolled Retirement Plan Agent—enrolled as a retirement plan agent under the requirements of Circular 230 (the authority to practice before the Internal Revenue Service is limited by section 10.3(e)).

▶ **IF THIS DECLARATION OF REPRESENTATIVE IS NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THE POWER OF ATTORNEY. REPRESENTATIVES MUST SIGN IN THE ORDER LISTED IN PART I, LINE 2.** See the instructions for Part II.

Note. For designations d-f, enter your title, position, or relationship to the taxpayer in the "Licensing jurisdiction" column. See the instructions for Part II for more information.

Designation—Insert above letter **(a–r)**	Licensing jurisdiction (state) or other licensing authority (if applicable)	Bar, license, certification, registration, or enrollment number (if applicable). See instructions for Part II for more information.	Signature	Date
a	MS	8649		3/7/16
a	MS	100073		3/7/16

July 13, 2016

Southwest Virginia Health Authority
c/o The Honorable Terry G. Kilgore, Chairman
851 French Moore Jr. Boulevard, Suite 178
Abingdon, VA 24210

Dear Authority Members:

We are pleased to respond to your May 27th, 2016 letter on behalf of the Board Chairs and Boards of Directors of Mountain States Health Alliance and Wellmont Health System. Please find attached the additional information you requested, which we hope will assist you in the process of deeming complete our application for a Cooperative Agreement. We believe the benefits of the proposed cooperative agreement are substantial, and given the increasingly difficult environment rural hospitals are operating in, we believe there is an urgency to completing this process.

We point to an article this week published in *Governing* Magazine[1], which asked the very question, "with hospitals in critical condition, can rural America survive?" The article states that rural hospitals "*are very much an endangered species. Nearly 30 percent of the nation's 2,000 or so rural hospitals are likely to close in the next two years. Rural hospitals have faced closure crises before, particularly in the late 1980s. This time around, however, the threats run deeper and are more challenging. While some states are taking steps to save hospitals operating in rural areas, there are growing barriers to the financial sustainability of these institutions. The decline and possible fall of rural hospitals mirror an existential question: Can rural areas themselves survive?*" The article goes on to highlight that more than 1/3 of rural hospitals were operating in a deficit in 2013, the last year the full data is available. This data along with Sheps Center data that 76 rural hospitals have closed since 2010 is compelling.

Despite several hundred millions of dollars of capital investment in Southwest Virginia, more than 1/3 of the rural hospitals operated by Wellmont and Mountain States in Southwest Virginia have operating losses, and as further detailed in this letter, those losses are supported by other hospitals within each of our systems that are increasingly unlikely to be able to continue to do so in the status quo environment. While we would certainly welcome financial support from the state, we believe we have proposed an innovative solution that permits our own region to sustain access to health care in these communities. In fact, *the only plan which guarantees continued access is the proposal we have made.* Given the ongoing losses, and expected continued increasing challenges, we believe time is of the essence.

As members of the Authority, and residents of Southwest Virginia and Northeast Tennessee, we share the Authority's vision "to achieve continuous improvement in the health and prosperity of the region". As we revel in Southwest Virginia's rich natural resources and traditions, home to generations of families who connect their roots back to pioneer days and celebrate the area's heritage in country music, farming, and coal mining, we also believe there is an alternative to the future painted by the *Governing* article. To the degree our health care economy contributes to the well-being of our communities, we believe this part of our future is in our hands if we choose for it to be.
While there is much to celebrate about our heritage and our culture, we also understand with the Authority that we stand at a crossroads. As the area's traditional major industries are suffering, losses

[1] Mattie Quinn, *Governing States and Localities,* July 2016.

of well-paying jobs are escalating. The population is aging and population growth decreases further as more of the region's young people seek new opportunities elsewhere. In fact, in some Southwest Virginia communities, the population has declined as much as 9 percent in the last five years. This negative demographic trend has led to despair in some communities, leading to rates of substance abuse and opioid induced deaths among the highest in the nation. Poor health habits which have persisted for generations have led to higher rates of diabetes, cardiovascular disease, and cancer and are stubbornly resistant to change.

Health care in general, and especially rural health care in America, is also at a crossroads. Previous federal policies and economic prosperity led to the construction and operation of hundreds of small rural hospitals across the United States, including those in Southwest Virginia. Hospitalization in the past was the default medical option of the day, and the region benefited not only from more hospital beds, but also the competition between Wellmont and Mountain States to control these resources and the revenue they generated from inpatient and surgical referrals.

The competition for bricks and mortar and the human resources associated with them were deemed essential to create spokes for the tertiary hubs that are at the center of each health system. But this era of acquisition and new construction resulted in a business model and duplicated capacity ineffectively aligned with recent and accelerating changes in reimbursement policies, along with the accumulation of significant levels of debt by both health systems. Our heavily-bedded infrastructure, largely established during stronger economic times where hospitals received reimbursements well in excess of their costs, now creates harsh realities.

The reality is simple. Robust competition has led to overcapacity, higher debt, and as you evidence in your letter, several indicators that the competition and cost resulting from it did not result in better quality.

What has happened to change this landscape from one where our systems preferred the competitive model to one where we believe the only option is a collaborative one? After 2008, when the federal government began to finally face the harsh fact that the cost of American health care was spiraling out of control, reimbursements began a fast pace of reduction further fueled by the nation's own budget crisis. The Affordable Care Act created a trade-off of payment cuts in exchange for expanded coverage. *Our region only got the cuts*. And these cuts were applied to payment rates which federal policy dictates are the third lowest payment rates in the United States among the hundreds of regions as identified by the federal government.

Businesses also began to grapple with the implications of the Affordable Care Act and started enacting high deductible plans to stave off dramatic cost increases. Hospitals could no longer rely on commercial payers to offset the losses from Medicare and Medicaid. All payers began implementing value-based purchasing models placing payment at risk – a payment model which incentivizes physicians to reduce cost and reduce the use of hospitals. This began a reversal of the payment model for hospitals which had previously incentivized payments based on procedure volumes in expensive buildings full of expensive equipment.

The changing reimbursement landscape has led to several consequences for hospitals:

- Hospital admissions have fallen nationally as outpatient services and medical/pharmaceutical treatments replace the need for hospitalization,
- Physicians are increasingly using "observation" status rather than admitting patients to hospitals. With this status, the patient remains in the hospital, often receiving the same treatment they would receive if they were admitted as inpatients, but the payment is significantly lower notwithstanding the fact the costs remain the same for the hospital, and
- Physicians are more assertively trying to keep patients from being admitted to the hospital, in large part because federal policy and commercial insurance companies are incentivizing them to do so.

Admission rates in our region generally range from 127 admissions per 1,000 population to 150 admissions per 1,000 population. Nationally, the range is closer to 90 admissions per 1,000 population to 110 admissions per 1,000 population. Recent trends indicate that our region's use rates are falling, and will continue to fall to more mirror the national trends. As high managed care penetration and risk based arrangements for physicians began more than a decade ago in suburban and urban areas of the nation, these models, combined with the new government payment policies, are now emerging in rural and non-urban areas. We estimate, based on these models, that admissions in our region will decline by somewhere between 14,000 admissions and 30,000 admissions. Plainly, this represents hundreds of millions of dollars of lost revenue to the hospitals, and an indisputable mortal challenge to each system's ability to sustain operations in the same manner the region has become accustomed to.

As we have highlighted, population stagnation is a significant headwind for our region's hospitals. And it is not projected to improve. Looking specifically at the pediatric population of the entire region, for instance, it is clear the counties in our service area in Southwest Virginia and Upper East Tennessee face a crisis. In the last five years, the population of children ages 0-17 in Southwest Virginia has declined in almost every county by a rate ranging from 3.4 percent to as much as 17 percent. In the counties representing Upper East Tennessee, the pediatric population has declined by rates ranging from 1.5 percent to as much as 8 percent. Throughout the service area, the pediatric population has declined by an average 5.3 percent over the past 5 years and is projected to decline by 3.3 percent over the next 5 years. This decline in pediatric population, when combined with the 10 percent decline in pediatric inpatient use rates, creates a serious challenge which is not helped by fragmented efforts of two separate systems. We believe the best chance for providing an organized delivery system for children which has a chance to sustain itself will depend upon the combined efforts of both health systems achieving operating synergy and making the proper targeted investments.

The New Health System has set forth significant commitments to expanded children's resources in our region. These new specialty resources and new access points are needed regardless of this population decline. But, supporting these resources is not possible in a status quo environment where the two health systems are unable to effectively align resources and manage pediatric needs in a fully collaborative model. Without the merger, challenges such as the declining pediatric population further jeopardize the region's ability to develop and sustain these highly specialized, expensive, but needed, services.

In other, more urban and suburban markets, hospital systems have been buffered from admissions (and revenue) decline because their populations continue to experience considerable growth. There has been no population growth in our region in the last five years, and as stated previously, most of the Southwest Virginia counties our mutual hospitals operate in had population declines during this time period, with the decline being as high as 9 percent. The projection for growth in our region is a mere 1% in the next five years, and remains negative in a number of Southwest Virginia counties. In addition to the population stagnation we are experiencing, the federal policy leading to the unfair Area Wage Index methodology used to help determine local Medicare rates results in our region experiencing the 3rd lowest payment rates in the nation. Our region has seen annual declines in our Wage Index adjustment for over a decade while California, Massachusetts and other high cost areas continue to see theirs climb. Combine these factors with the fact that we continue to experience high rates of uninsured individuals and increasing bad debt as patients cannot afford to pay their increasingly high deductibles, and it is clear Southwest Virginia's hospitals are at a national disadvantage.

Even as those regions have higher payment rates and population growth, their hospital systems are also consolidating. In the last month, the California Attorney General entered into a consent agreement permitting a merger creating the 3rd largest non-profit health system in America. The only two hospital systems in Huntington, West Virginia were last week approved by their state to merge interestingly using as a model the same statute Virginia passed one year earlier which would permit the merger we have proposed. In Illinois, the courts ruled in favor of a merger of hospitals there, and in Pennsylvania, the court ruled in favor of a merger there. In each of these cases, which have occurred in the last two months, the hospital systems made commitments similar to the commitments our proposal makes with respect to the elimination of competition, but *none of these other mergers comes close to making the commitments we are making in terms of investment back into our region*. In the Hershey, Pennsylvania case, the court said that the federal government has "created a climate that virtually compels institutions to seek alliances such as the hospitals intended here." We agree with the court's statement, and believe it applies directly in this case.

In reality, rural Southwest Virginia hospitals have been struggling for some time. This was never clearer than when Lee Regional Medical Center closed in 2013—among 76 rural hospital closures across the country in recent years. Today, the rural hospitals operated by the two health systems have operating losses of at least $19.5 million annually (not including capital investment) and must be subsidized to stay open, and $11 million of this is directly related to the Southwest Virginia facilities. These losses are expected to increase. The competitive model existing to date in the region has resulted in seven hospitals operated by Mountain States and Wellmont operating over eleven Southwest Virginia counties with an average daily census of only 173—an average occupancy of 33% percent and about the typical census of a single hospital. So, the same census that would normally occur in one hospital is divided among our 7 hospitals, each with substantial fixed cost to support the low volumes. As low volumes become lower, the fixed administrative cost of sustaining the two systems independently will increase as a percent of the total cost of the systems, since the administrative cost is duplicative and fixed.

The pressures identified in this letter do not only apply to the Virginia hospitals. They also apply to the Tennessee hospitals operated by Mountain States and Wellmont. And while, historically, the larger tertiary hospitals in Tennessee have helped offset these losses, and have helped subsidize the capital funding of the Virginia hospitals, these pressures increasingly challenge each system's ability to continue this model. Independently, both Wellmont and Mountain States have come to the long-studied conclusion that it is not possible to thrive in the status quo environment. In this specific market, competition for market share between the two systems has focused system resources on duplicating revenue-producing services and has not generated funds sufficient to supply the needed sub-specialty services, mental health services, or substance abuse services. It has certainly not produced investments in population health management or community health improvement, which are desperately needed based on the health status of the population. Under the growing pressures outlined above, it will only get worse.

Though both organizations are currently financially stable, remaining independent or seeking to sustain the current levels of competition, would jeopardize rural facilities, rural access, and risk substantial job loss. In the best interests of the region, the options before the two health systems are to merge/be acquired by systems from outside the market or to set aside years of status-quo producing competition and merge with one another.

After significant deliberation, the boards of the two health systems determined the best solution for our unique challenges is the innovative solution of a local merger. Our analysis concludes any out of market system seeking to acquire Wellmont or Mountain States would seek to gain efficiency by reducing unprofitable services without the promise of reinvestment in community health, academics and research, specialized services, or mental health and substance abuse initiatives.

To be clear, any system acquiring Wellmont or Mountain States will likely do three things:

- They will seek to leverage the relative size of their system to seek higher pricing from payers. At least one study has shown this type of merger "allowed hospitals to increase average prices by around 17 percent, with some specifications suggesting even larger increases."[2]
- In an effort to seek synergies for their system, they will likely eliminate local corporate and administrative jobs, which we believe will result in a loss of 600-1,000 high wage jobs in our region.
- They will close unprofitable services and facilities, which is standard procedure for an out of region system seeking to mitigate losses.

In the alternative model where an out of market acquisition occurs, there will be millions of dollars of annual synergies through the deployment of these three strategies, and all the synergies will inure to the benefit of the balance sheet of the system which acquires Wellmont and/or Mountain States.

Conversely, while there will, indeed, be synergies between Mountain States and Wellmont, most of which occur in Tennessee, the benefit of the synergies results in the dollars being reinvested as

[2] Lewis and Pflum, October 26, 2015, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*

described in the Application. Because of those commitments alone, pricing will increase more if our proposed merger is not approved.

Fortunately, the Southwest Virginia legislative delegation worked to establish the Cooperative Agreement mechanism to allow the two health systems to create an innovative model of regional health care and community health improvement with any potential negative consequences of reduced competition under active supervision from the Commonwealth. The model the delegation created was so effective, the Legislature in West Virginia used it as a model, passed it and applied it to what is now approved by West Virginia as the most recent merger of two local health systems. Additionally, we will add that we are not aware of any case where state or federal agencies have brought legal action against a hospital system operating under a cooperative agreement for increasing pricing unreasonably or taking any anti-competitive action harmful to consumers. In fact, in the case of Mission Health in Asheville, which operated under a similar agreement for 20 years, pricing was lower than its peers in North Carolina. Mission has been named a top 100 hospital in America for 7 consecutive years, and a top 15 health system for 3 consecutive years. In an interesting development, the Department of Justice recently filed a lawsuit alleging anti-competitive behavior, but not against Mission. Instead, they alleged Carolinas Health System behaved anti-competitively by using steering provisions in its contracts with every major payer. While we don't know if Carolinas did what was alleged, we do know that the alleged behavior would be prohibited by a Cooperative Agreement. We also know that no such allegation, or any allegation by the government, was ever made against Mission, a system with significantly higher market concentration than Carolinas, but which operated under a regulated COPA.

Because of all the challenges mentioned, it is difficult to envision an effective business model for the health care system in Southwest Virginia either under the status quo of competition or with the risks presented by an out-of-market merger or acquisition. The New Health System, however, envisions a business model that truly lives up to its not-for-profit tax status by delivering community benefit defined in an enforceable Cooperative Agreement under active supervision by the Commonwealth. The New Health System has committed to measurable price reductions, discrete dollar investments in new services and standards of conduct to not disadvantage payers or other providers in the region. And unlike the relatively weak link between community health needs and community benefit spending that is now required under IRS rules, the New Health System is committed under the terms of the Cooperative Agreement to working collaboratively with the Commonwealth, the Authority and local stakeholders to invest more than twice the current level of community benefit spending on mutually agreed upon community health improvement goals.

We believe that the enclosed answers will help to further illustrate our commitment to this effort. Thank you for the Authority's continued time and attention to our application which we believe is truly an important step forward for the health and prosperity of Southwest Virginia.

Sincerely,

Alan Levine, President and CEO
Mountain States Health Alliance

Bart Hove, President and CEO
Wellmont Health System

RESPONSES TO QUESTIONS

SUBMITTED MAY 27, 2016

BY

SOUTHWEST VIRGINIA HEALTH AUTHORITY

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:	July 13, 2016

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APPLICANTS AND DEFINITIONS

The responses ("Responses") in this document are submitted by the applicants listed below ("Applicants") in answer to questions ("Questions") received by letter dated May 27, 2016 from the Southwest Virginia Health Authority ("Authority"). The Questions request additional information in connection with the Authority's review of the Application for a Letter Authorizing Cooperative Agreement (the "Application"), which was submitted by the Applicants to the Authority on February 16, 2016 pursuant to Section 15.2-5384.1 of the Code of Virginia.

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Throughout the Responses, Mountain States Health Alliance is referred to as "Mountain States," and Wellmont Health System is referred to as "Wellmont." Mountain States and Wellmont are also referred to individually as a "Party" or "Applicant" and collectively as the "Parties" or "Applicants." Capitalized terms used in the Responses and not otherwise defined shall have the meanings given to them in the Application.

ACCESS

1. On page 86 the Application refers to eliminating duplication of services. Please provide a table showing where there is duplication or perceived duplication of services.

RESPONSE: As demonstrated in **Exhibit 1A** to these Responses,[1] there is limited duplication or overlap of the Applicants' services in the Virginia portion of the Geographic Service Area, which is due in large part to the fact that several of the Applicants' hospitals in Virginia are very small hospitals with limited sets of inpatient services. The material duplication exists primarily in Wise County where the Parties collectively have three hospitals. The Southwest Virginia region will retain competition from hospitals not associated with the New Health System.

Thus, while the Applicants have committed to keep all hospitals open as clinical and health care facilities for at least five years, Wise County is the one area in Virginia that is most likely to see services aligned across the three existing facilities in that county. The Applicants believe that service alignment in Wise County is likely to inure to the community benefit by using current capacity and locations to provide other health care services needed by its residents. There are also factors outside of the Applicants' control that affect Southwest Virginia and drive the need for service changes there, including in Wise County. The communities and hospitals throughout Southwest Virginia have generally experienced declining population, declining inpatient admissions, and also declining admissions per capita over the last several years.[2] In Wise County, these declines make it even more difficult to sustain three standalone hospitals each attempting to serve a broad range of inpatient services. With re-purposing, however, Wise County is likely to see new services added that do not currently exist in the community, such as expanded outpatient or physician services and make better use of capacity—minimizing any potential negative economic impact. An assessment of need will take place in Wise County utilizing the process and policy outlined in the Application, which will involve local physicians and members of the community.

The New Health System hopes that by implementing a more efficient system of operations – through more efficient use of existing infrastructure and more patient-focused, need-based care – financial losses in the Virginia hospitals can be curtailed or eliminated. However, the New Health System commits to continue funding any levels of operating loss in the Virginia hospitals for at least five years as it keeps those facilities open and works to have them productively meet the needs of people in the region through a better, more effectively aligned system of care.

2. Will any facilities close or any services cease being provided in existing facilities and locations by the Applicants prior to the adoption of the proposed Cooperative Agreement?

RESPONSE: The Applicants have no plans to close any facilities or services prior to the approval of the proposed Cooperative Agreement and the closing of the transaction. In fact, the Applicants do not anticipate any facility closures and have committed to continue operating all

[1] **Exhibit 1A** includes duplication of services in Virginia and Tennessee and shows discharges by hospital for each Wellmont and Mountain States hospital. A threshold of 25 or more discharges was used to represent a hospital having a specific service line (e.g., cardiac surgery); service lines were defined by groups of DRGs. Many of the smaller Mountain States and Wellmont hospitals offer only limited range of inpatient services. .

[2] **Exhibit 1B** includes data for each of several recent years about inpatient admissions, population and inpatient use rates in each of the Southwest Virginia counties of the Geographic Service Area.

hospitals as clinical and health care facilities for at least five years if the Cooperative Agreement is approved. This commitment will not occur without the merger. It is important to note that, withouth the merger, it is likely each system will require cost reductions in order to sustain cash flow. This will be necessary to offset reductions in inpatient use rates, which in conjunction with declining population trends in the Virginia counties creates serious challenges for these hospitals.

In regard to services, frequent evaluation is critical to maintain the highest quality services. Service offerings are often dependent on physician availability, which is sometimes out of the Applicants' control. If circumstances indicate that any major service offerings must change in Southwest Virginia prior to the adoption of the proposed Cooperative Agreement, the Applicants will advise the Authority.

3. Recognizing that there may be considerations for the maintenance of facilities and services, how many acute care hospitals will be maintained in Virginia long-term following the merger? What services will continue to be offered during the entire initial five year period?

RESPONSE: The Parties do not anticipate closing any hospitals in Southwest Virginia following the merger and have committed to the ongoing operation of all the Parties' facilities as clinical and health care institutions for at least five years if the merger is approved. Over the long term (which the Authority has defined as 6-10 years), the New Health System may determine the need to repurpose beds in a market where beds and space are underutilized or there is unnecessary duplication of services. In such a situation, alternative uses of the beds will be considered based on the health care needs that exist in the affected community. In the changing environment of health care, it is impossible to predict what the health care landscape will look like beyond a five-year horizon — which is the rationale for the committed time period set forth in the Application. That said, the Applicants' stated commitment in the Application to continue access to needed health care services in each community of the Geographic Service Area beyond the initial 5-year period includes retaining essential inpatient and outpatient services in geographic proximity to the populations currently receiving care from the Applicants.

The commitment to maintain access in these communities does not exist without the merger, as the Parties' existing rural facilities continue to become more financially constrained. The Applicants are not alone in this trend of financial pressure facing rural hospitals and difficulties in sustaining inpatient services. In fact, more than 70 rural hospitals have closed since 2010, and more than 600 could be vulnerable going forward.[3] According to the University of North Carolina Sheps Center, 76 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia.[4] The current system of health care in the United States was built upon a

[3] *See* iVantage's 2016 Rural Relevance: Vulnerability to Value Study, which assesses rural and Critical Access Hospital performance; Ellison, A. (2016, February). The rural hospital closure crisis: 15 key findings and trends. Becker's Hospital CFO. Retrieved from http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html; Rural Hospital Closures: 2010-Present (2016); and Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, and Pink GH. 2016. The rising rate of rural hospital closures. Journal of Rural Health 32(1):35-43.

[4] *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 Application was filed in February, 2016, including two rural hospitals in Tennessee.

hospital-centric model. Today, the model of care is shifting away from hospitals to preventative and outpatient services. In rural markets, declining inpatient use rates and negative population trends are creating enormous financial strain on hospitals. Without the investments Mountain States and Wellmont have made in the Southwest Virginia hospitals, for instance, it is unlikely all of these hospitals would remain open. The financial headwinds are also impacting the larger hospitals within the two systems. Without the merger, it is likely that Mountain States and Wellmont will need to reduce non-core expenses in order to sustain the major access points in each system. Thus, in a status quo environment, the rural hospitals are likely to experience reduced financial support and increasing vulnerability. The current financial support that Mountain States and Wellmont provide for the Virginia hospitals can only be maintained in the future through the overall efficiencies gained through the merger as set forth in the Application. Without the merger, no such commitment exists, and Mountain States and Wellmont cannot guarantee that services, or even hospitals, will remain open in these communities. Moreover, the Applicants are making affirmative commitments to provide continued care access in its communities that extends beyond maintaining facilities for specified time periods after the merger is closed, and these commitments will better meet the needs of patients in the region and improve access to cost-effective care for them.

4. What services will be available at each nonhospital facility in Virginia during the initial five-year period? How long will the Applicants commit to maintaining these services?

RESPONSE: The commitment set forth in the Application to maintain operation of all the Applicants' hospitals as clinical and health care institutions for at least five years specifically addresses hospital facilities. However, the Applicants' broader commitment is to regularly assess community needs and to seek to meet those needs through an effective regional system of prevention, physician, inpatient, outpatient, and post-acute services. For example, the Applicants have committed to conduct ongoing physician needs assessments in each community. Through ongoing efforts to recruit physicians, the Applicants target the ultimate variable to ensuring services remain available. Physician services and ambulatory access points will be created or maintained based on the needs of the population in specific geographic locations, but without unnecessary duplication, and in some cases, through competition with unaffiliated entities. Avoidance or reduction of duplication will allow for a more effective allocation of regional resources and will position the New Health System to add services that may not be justified under the lower, divided volumes that exist today.

5. We have reviewed the New Health System Alignment Policy, but it strikes us as being short on specific metrics for determining when to close facilities or services. The Applicants have come up with an elaborate scoring system at the end of the Application with points assigned to various criteria. The Alignment Policy lacks that specificity and simply recites factors deemed relevant without any indication of the weighing of such factors. We are not saying that a point system is necessary and some flexibility is necessary to take into account circumstances and factors that cannot be fully anticipated currently. Notwithstanding the need for some flexibility, we seek greater clarity on relevant criteria and how they will be weighed. We also believe that taking into account federal designation of areas as medically underserved areas or health manpower shortage areas is relevant. What role do the Applicants believe should be given to the Authority in reviewing planned closures? How will the New Health System weigh travel time and lack of access to public transportation in making decisions?

RESPONSE: Decisions about regional service alignment are complex and involve many factors, including demonstrated community need for a service; availability of qualified, experienced personnel; unnecessary duplication of services that are readily available but not being utilized to capacity; impact on patient travel times for services; resource requirements to provide the service; balancing the commitment of resources among all needed services; and obligations of the New Health System under the State Agreements. In each case, the weighting of factors will depend upon the circumstances in that community. These decisions will not be conducive to the use of a scoring system because of the complexity involved in the decision-making, but a matrix including the factors listed above and others would be used by the New Health System leaders, physician leaders, the Board, and other involved stakeholders when making these decisions. This process must provide the flexibility to consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders.

Importantly, the Applicants have committed that no major service will be discontinued within the first two years without a super-majority vote of the New Health System Board if the discontinuation would render the service unavailable in the affected community. Proper management of this decision-making process is a fiduciary responsibility of the independent, public benefit, not-for-profit New Health System Board and cannot be shared or delegated. However, the Parties are committed to the effective communication of these decisions to the community and the Authority as they relate to Virginia facilities and services.

6. What long-term commitment will the Applicants make regarding the Virginia hospitals, specifically, which ones are you committed to maintaining and not repurposing? If the Applicants are unwilling to make a commitment with respect to specific facilities, is there a certain number, including specifics on beds and services?

RESPONSE: As stated in Response #3 above, it is not possible for the Applicants to forecast health care needs beyond five years due to the dramatically changing climate of health care nationally, particularly in regard to inpatient versus outpatient utilization. For this reason, the Applicants have made a clear commitment to keep all current hospitals open as clinical and health care facilities for at least five years if the merger is approved. No such commitment by Mountain States or Wellmont exists today. In fact, the financial environment in which Mountain States and Wellmont currently operate is expected to become more and more difficult, particularly for rural facilities that are currently operating significantly under capacity and inefficiently in areas where populations are declining. This is substantiated by the average daily census of each rural facility compared to the staffed capacity as set forth in the Application.[5] The assurance to maintain current hospitals for five years will be funded through an effective re-alignment of regional resources and will provide the best long-term solution for regional health care, particularly in the rural areas served by the Applicants. Further, the savings from elimination of duplicative services will enable the investments in the development of new, needed services which are not currently available in certain communities along with the preservation of more jobs and advancement of more economic opportunity.

7. We have reviewed the Applicants' current charity care policies. What will be the charity care policy for the New Health System? What commitments will the New Health System make to the dollar level of charity care (or stated as a percentage of another amount such as net revenue)? Please

[5] *See* Application Section 5, Tables 5.2 and 5.3 (pages 18-19).

explain whether the metric is cost or forgone charges. To what extent will the Applicants commit to a charity system wherein qualified patients' entitlement to charity care is decided "up front" so that individuals know they have access and know in advance their financial responsibilities and discounts on services versus charity care being largely provided as a result of write-offs after all attempts at collection have been unsuccessful?

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.

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.

8. With respect to charges for medically necessary services for which patients are personally liable, whether by reason of being uninsured or having coverage that does not extend to such charges, will the Applicants commit to not charging more than the amount that they would have collected from Medicare for such services?

RESPONSE: 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,[6] 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.

9. The Application mentions that the Applicants intend to have charity clinics. Please provide a more specific description of these clinics including services and areas served. How will the clinics integrate with existing charity care clinics in the region?

RESPONSE: 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.

10. The Applicants have included in their Geographic Service Area Wythe County in Virginia which is closer to Roanoke than to the Tri-Cities area and the Applicants have also included Hamblen County and Cocke County in Tennessee which are closer to Knoxville. Why were these counties included and what is the market share of the Applicants in each of these counties presently?

RESPONSE: All of the Wellmont and Mountain States physical facilities and provider locations are located in Virginia or Tennessee and are subject to state regulations in these two states. While the Applicants recognize that "geographic service area" may be defined in different ways,

[6] 26 CFR § 1.501(r) (6).

the Applicants have defined the "Geographic Service Area" in the Application as the twenty-one counties in Virginia and Tennessee where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Virginia and Tennessee 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 Cooperative Agreement in Virginia and the COPA in Tennessee. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured. In fact, ninety-eight percent (98%) of the combined patient discharges come from the Geographic Service Area – the 21 counties in Virginia and Tennessee.[7]

Even though Wythe, Hamblen and Cocke Counties are located between metro areas in Virginia (Roanoke/Tri-Cities) and Tennessee (Knoxville/Tri-Cities), the hospitals located in Wythe, Hamblen, and Cocke serve patients not only from their own counties but from other counties located in the Applicants' Geographic Service Area. In other words, there is meaningful outmigration from the counties in which Mountain States and Wellmont have facilities to Wythe, Hamblen and Cocke Counties. As shown in **Exhibit 10A** attached to these Responses, the Wythe, Hamblen and Cocke hospitals attract between 11% to 34% of their patients from within the Geographic Service Area, indicating that these hospitals are in competition with the Applicants' facilities and other competing facilities located within the Geographic Service Area. In addition, the Mountain States and Wellmont attract patients from Wythe, Hamblen and Cocke Counties to their facilities (ranging from 2% to 12% as shown in **Exhibit 10B**), also indicating overlap and competition with the Applicants. There is little relevance to the county lines in this region; the needs of patients from these counties are aligned with those of all the other Southwest Virginia and Northeast Tennessee communities included in the Geographic Service Area. People from these regions utilize services from each of the Applicants—particularly for tertiary level needs. In combination, the tables in **Exhibits 10A and 10B** to these Responses include data and information on the residents of each of Wythe County, VA, Cocke County, TN and Hamblen County, TN – total volumes of inpatient services used and the locations of care used – and on the hospitals located in these counties – and the meaningful levels of patients drawn from the Geographic Service Area to these independent hospitals. As requested, the tables in **Exhibits 10A and 10B** show the share for inpatient services attributable to the Applicants in these counties (between 2-12%), as well as the use by the Geographic Service Area's residents of the hospitals in these counties.

11. What will be the New Health System's primary and secondary service areas? (See definitions in the Authority's guidance for applications). How, if at all, do the Applicants expect the New Health System's service area to differ from their description of the Applicants' existing service areas?

RESPONSE: The Parties believe that the Geographic Service Area encompassing the 21-county area in Southwest Virginia and Northeast Tennessee outlined in the Application accurately reflects the Applicants' current and predicted future service areas. The Geographic Service Area reflects the service area over which the Applicants intend to develop a fully integrated health care delivery system with supporting infrastructure, and is the area currently served by the

[7] *See* Application Section 5 (pages 14-21) and the accompanying Exhibits 5.1 and 5.2 for a more detailed description of the Geographic Service Area and the hospitals and other facilities that serve residents of the area.

Applicants. As noted above in Response #10, ninety-eight percent (98%) of the combined patient discharges come from the Geographic Service Area - the 21 counties in Virginia and Tennessee. The Applicants do not expect the New Health System's service area to differ from this 21-county area.

In response to the specific request for definition of a primary and secondary service area using the 75% and 90% methodology, as defined by the Authority's guidance, **Exhibit 11A** to these Responses uses the New Health System's discharge data for CY2014 to identify the zip codes that constitute both the 75% and 90% service areas for the New Health System based on the combined discharges of Mountain States and Wellmont. These zip codes are presented in table format and in a map in **Exhibit 11A**.

Exhibits 11B and 11C include maps of the Mountain States and Wellmont discharges, respectively, for the zip codes that constitute each of their 75% and 90% service areas defined using the Authority's guidance. As the maps in **Exhibits 11B and 11C** illustrate, the 75% areas for Mountain States and Wellmont are somewhat different in geographic scope, yet collectively include most of the counties in the 21-county area; the 90% areas also include the vast amount of the area, with some counties included for Wellmont (and not for Mountain States) and the reverse. We note that the 75%/90% areas include many zip codes that are served by hospitals located physically within the areas and others just outside. This is not evident on the maps because the 75%/90% areas by definition are based only on Applicants' data and do not show overlap with other health systems.

The Parties note that the 75% and 90% service areas requested do not represent to them an accurate depiction of their service area. The Parties believe that the 21-county Geographic Service Area (defined in the Application) most accurately represents their service area for the reasons outlined in Response #10: the meaningful outmigration of residents within the 75%-90% area to competitors in Wythe, Cocke and Hamblen counties as well as to hospitals elsewhere including preeminent academic medical centers in nearby Virginia and Tennessee; the numbers of residents within these three counties who seek care within the 21-county area; the alignment of the needs of patients from these three counties with all of the other patients in other parts of the 21-county area; and the location of the Parties' facilities across the area. The Parties have included data in the Application showing the range of service offerings provided by the Parties and the inpatient services offered to residents of the Geographic Service Area by numerous other hospitals. A listing of these hospitals was provided in Application Exhibit 5.1.

Finally, we note that Application Exhibit 5.1 presents maps of the 75% and 90% service areas of each of the Applicants' individual hospitals. The Applicants include as a supplement to the maps in Application Exhibit 5.1 a table showing the zip codes that constitute the 75% and 90% service areas for each of the Applicants' individual hospitals, attached as **Exhibit 11D** to these Responses. As noted in the Application, many of the hospitals are very small and rural with service areas of just a few zip codes, and with very limited overlap with other hospitals. This demonstrates that some of the scope of the Applicants' combined service area is affected by the fact that the outlying hospitals are small with limited discharge volumes.

12. Looking solely at the primary service area as defined in the guidance for the Virginia application, what is the existing combined market share of the two Applicants for: (1) inpatient

hospital services; (2) outpatient clinic services (whether provider- based or not provider-based); (3) outpatient radiology services; and (4) outpatient surgery?

RESPONSE: The Parties attempted to calculate the information requested, but the limitations on available data make the estimates inaccurate or incapable of precise calculation, particularly for any service other than inpatient services. In responding to this request, we used inpatient discharge data for CY2014 and derived services areas based on the Authority's guidance. We used the 75% service area based on Wellmont's and Mountain States' combined discharges as the basis for share calculations for inpatient services. For outpatient services, without discharge data, we were not able to re-define service areas. We approximated a service area for outpatient services by excluding entire counties from the 21-county service area if they did not appear to be in the service area; this was done by visual inspection and review of the 75%/90% area map in **Exhibit 11A** to these Responses.[8]

Inpatient Services. **Exhibit 12A** to these Responses presents estimated market shares for the 75% area of the Applicants for inpatient services.[9] We note that the resulting share substantially overstates the combined share of the Applicants and the competitive pressures on the Applicants because it excludes many relevant competitors, including some of the most prominent tertiary and academic medical centers as well as community hospitals located outside the 75% area but that compete for patients inside the 75% area. We respectfully submit that data and information using the full Geographic Service Area and all of the relevant hospitals should be included as part of the record for review of this merger. We do not believe the 75% volume area represents a relevant, accurate geographic market for assessment of the merger. **Exhibit 12C** to these Responses is included to show the New Health System's share of inpatient services for the Geographic Service Area.

Outpatient Services. With respect to calculation of outpatient services, it is important to note that the data is limited. The data that VHHA reports to the Commonwealth (and thus is publicly available) is incomplete: (i) the data do not include Emergency Departments, and (ii) the data only include six outpatient, ambulatory surgery groups (facial plastic surgery, breast surgery, colonoscopy, laparoscopic surgery, knee arthroscopy, and hernia repair). If facilities perform other outpatient surgeries/procedures, VHHA includes them in the outpatient data for VHHA members, but this data is not reported to the Commonwealth and therefore is not publicly available.

No publicly reported data exist for Virginia outpatient services that allows for accurate volume comparison or market share calculation across independent as well as hospital-based services. From time to time, organizations may use purchased claims data or other sources of information to approximate outpatient data. However, these methods are based on proxy calculations or algorithms and are therefore unreliable estimations for purposes of inclusion in the Application.

In an effort to respond to this request, we provide data and information for the outpatient services in the 75% area separately for imaging, surgery, and clinic services as well as other

[8] For example, to define the 90% area, we excluded Wythe, Hamblen, and Cocke Counties.

[9] Shares are reported in the far right column of **Exhibit 12A** based solely on hospitals located in the 75% area; the first column shows shares for all hospitals. For symmetry, we include **Exhibit 12B** to these Responses, which includes shares based on the 90% service area.

outpatient services in **Exhibit 12D** and provide shares based on counts of facilities. In an effort to be responsive to the request for service area analyses, we excluded outpatient facilities located in counties that appear to be wholly outside of the 75% service area defined using the Authority's guidance. While we believe that these adjacent facilities are competitive alternatives, we present shares in **Exhibit 12D** excluding some of these competitive facilities. We present the comparison of the 75% area data with the full set of outpatient facilities in **Exhibit 12E**.[10]

13. What further information can be provided regarding the insurance products and plans that the Applicants anticipate will be available in the New Health System? Are the Applicants planning on forming an ACO? For Medicare? Non-Medicare?

RESPONSE: The New Health System does not plan to offer any insurance products and, instead, plans to partner with existing insurance providers and self-insured employers in the market to provide value-based, shared savings, and, in certain situations, shared risk payment arrangements. The Cooperative Agreement provides the opportunity for the Applicants to move forward more promptly and effectively to align care and develop models and metrics that address these new types of contracts. Both Applicants have some experience in these areas that will enable them combined to work together more effectively. Mountain States currently operates an accountable care organization ("ACO") in Virginia, AnewCare, which participates in the Medicare Shared Savings Program ("MSSP"). It is likely that the New Health System will continue to operate this ACO in Virginia after the merger closes. Both Wellmont and Mountain States currently participate in some value-based, shared savings, and risk-sharing payment arrangements with their existing insurance providers for non-Medicare business, and the Parties anticipate that all of those arrangements will continue through the New Health System after the merger closes. The Applicants further anticipate that the New Health System will engage more extensively with payers in value-based, shared savings, and risk-sharing arrangements and may partner with independent physicians and providers in the formation of a clinical network that will support the goals of various models developed by the payers. Commitments and investments with regard to IT, infrastucture and population health all serve to align incentives and promote the capacity of the New Health System to be more effective in these forms of contracting and to achieve benefits.

14. What are the current number of licensed healthcare professionals by county and facility in Southwest Virginia employed by the Applicants and what is your projection on what that number will be following the adoption of the Cooperative Agreement?

RESPONSE: The Parties are compiling the information requested and will provide this to the Authority in a subsequent response as soon as possible.

15. It is noted in the Application that the New Health System will maintain three tertiary hospitals in Tennessee. Can the Applicants give commitments to Virginia on which Virginia hospitals the Applicants will keep open? What is the likelihood a tertiary hospital will open in Virginia in the next ten years? What factors would make opening such a facility more or less likely?

[10] **Exhibit 12E** excludes 5 facilities located in the Geographic Service Area that are single speciality or specific urgent care facilities.

RESPONSE: As noted in the Application, all existing Virginia hospitals will remain open as clinical and health care facilities for at least five years.

Tertiary hospitals are noted for high volume and the availability of highly specialized services, which require enough volume to support the ongoing skill development of staff. In a tertiary hospital, there must be sufficient physicians in each specialty, and highly-trained and specialized staff to support them. In order to attract and justify these specialized physician and staff resources for a tertiary hospital, there must be sufficient critical mass of patient population to support the investment. Because Southwest Virginia is geographically large, topographically divided and sparsely populated, the region does not have the ability to support such a tertiary hospital on its own. Travel patterns also vary from the Highway 23/Interstate 26 corridor and the Interstate 81 corridor, making effective placement of one tertiary center difficult and inconsistent with the goal of improving patient access. Finally, hospital use rates are declining in Southwest Virginia and nationally, and the need for more hospitals is in question. The objective of the New Health System will be to keep needed services in close proximity to where people live, to the extent it is practical and appropriate. For these reasons, the Applicants do not foresee a new tertiary hospital opening in Southwest Virginia. Notwithstanding this, the Applicants believe that tertiary services are ones for which patients are willing to travel, and are ones that many patients require only once or infrequently. Tertiary hospitals, including academic medical centers ("AMCs"), have very broad service areas. As such, the population in this region can be and is served both by the Applicants as well as a number of the State's and region's best AMCs. For these services, patients have alternatives, although the Applicants aspire to be the best alternative for local residents.

16. The Application references Dickenson County's facility. What does that reference mean for Dickenson County and this facility continuing operation during the five-year period of the Cooperative Agreement or following it?

RESPONSE: In the Application, Wellmont and Mountain States have committed that all hospitals in operation at the time of the merger, including Dickenson Community Hospital, will remain operational as a clinical and health care institutions for at least five years.[11] Without the savings realized from the proposed merger, there is no similar commitment possible by Mountain States to Dickenson Community Hospital.

It is important to note that the New Health System's Alignment Policy would 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 the affected community. Further, 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. The Alignment Policy is attached to the Application as Exhibit 12.1 and is discussed in detail in Section 12.b of the Application (pages 35-36).

The Applicants would like to note that Question 16 includes the wording "during the five-year period of the cooperative agreement." The Applicants expect that the Cooperative Agreement

[11] *See* Application Section 17, page 131: "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."

will remain in-place well beyond five years with modifications made from time to time as agreed upon by the Commonwealth and the New Health System; the Cooperative Agreement is not expected to be limited to a five-year period.

17. The Authority requests more information on the Level-1 trauma center, such as, where will this be located and how will the decision to locate the center be made?

RESPONSE: Currently Mountain States operates one Level I trauma center in Johnson City, Tennessee, and Wellmont operates one Level I trauma center in Kingsport, Tennessee and one Level II trauma center in Bristol, TN. Licensing requirements for Level I and Level II trauma in Tennessee (where each facility is licensed) are very similar.

Throughout Virginia, there are five Level I and four Level II trauma centers. Six Level I trauma centers and one Level II trauma centers operate throughout Tennessee. Best practice trauma care systems are focused on the entire *trauma system*, not simply independent facilities. The effectiveness of a trauma system depends on an integrated system of hospitals, trained care teams, EMS and transport trained to work well within common protocols.

The Applicants have made no decisions regarding the location of Level I trauma care. The decision will be made post-closing in accordance with the New Health System's Alignment Policy described in Section 12.b of the Application (pages 35-36), which requires thorough analysis of the relevant clinical and financial data, and input from physicians and other clinicians relevant to the service. Additionally, any decision to consolidate a service in such a way that results in discontinuation of that service in a community will require a super-majority vote of the Board of the New Health System for two years after the merger.[12]

18. Please address commitments of the New Health System related to the following:

a. Improving access to Ob-Gyn services in Southwest Virginia, including how the New Health System will specifically address those gaps resulting in an increase in the percent of women in the Authority footprint who receive early and adequate prenatal care to achieve state and national benchmarks;

RESPONSE: The solution is multi-factorial – while improved access to health care is important, improved inter-conception health of the mother, birth spacing, and actual utilization of effective pre-natal care can be even more important. The Applicants have outlined in the New Health System's Community Health Improvement Plan, attached as **Exhibit 18** to these Responses, the steps that will be necessary to make meaningful positive change in the region's pre-natal care. The Community Health Improvement Plan includes short-term and intermediate-term outcomes for population health improvements, which the New Health System hereby submits for consideration by the Authority and the Commonwealth.[13]

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[12] The Alignment Policy (with details of the Alignment Policy's decision-making process) is attached to the Application as Exhibit 12.1.

[13] The Community Health Improvement Plan is the first step in the New Health System's proposal and efforts to improve the population of the region's health over the next decade. The Community Health Improvement Plan

With respect to birth outcomes, there are several evidence-based strategies that lead to improvement, such as nurse family partnership, centering pregnancy programs, smoking cessation programs, and medication assisted treatment during pregnancy for mothers addicted to opioids. The Applicants intend to work collaboratively with the Authority, the Commonwealth and local Departments of Health and Community Service Boards to determine the most effective initiatives for each Southwest Virginia community.

As noted in the Application, improving birth outcomes is a key component of the New Health System's commitment to invest $75 million in population health improvement over the next decade in the Geographic Service Area.[14] The New Health System has committed to performing a physician needs assessment in each community every three years.[15] The New Health System has also committed to spending $27 million over ten years pursuing pediatric sub-specialty services, including recruiting and retaining physicians in the area, preferably by assisting independent physician groups who will identify and employ new physicians. The New Health System intends to employ physicians where independent practices cannot or choose not to employ these needed sub-specialty physicians.

However, money alone will not solve the problem. For example, even when Wellmont and Mountain States have the need, desire and the funds to recruit new physicians, the time to fill these positions often runs in the hundreds or even thousands of days. The Applicants along with the Authority and the communities in the region must be willing to design interventions that recognize the realities and health care patterns of each community and maximize the opportunities for pre-natal care improvement in each community. Changes in health care habits and patterns take time, and are often measured in five and ten year timelines.

b. Preserving existing primary care Graduate Medical Education ("GME") programs and positions in Southwest Virginia (programs in Norton, Big Stone Gap and Abingdon specifically). Does the merger anticipate moving around residency programs and positions as the only GME referenced in the application are in Tennessee? What commitments will the New Health System make to training residents in Southwest Virginia at Southwest Virginia facilities?

RESPONSE: While specific decisions about GME programs and positions have not yet been made, the Applicants do not anticipate significant movement of residency positions. The New Health System intends to continue training and graduate medical education throughout the system and the entire Geographic Service Area, provided federal and state funding continues. This includes the residency programs in the communities where they are currently offered. It is important to note that, prior to the agreement to merge, both health systems independently had begun implementing plans to reduce the number of residency slots. This reduction was halted, in part, because the health systems were committed to deploying synergies related to the merger toward improving, rather than reducing, residency and training programs.

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was developed in conjunction with the public health resources at ETSU and through results of the Community Health Work Groups, all of which is described in more detail in Application Section 15.a.F, pages 87-91.

[14] *See* Application Section 13.b, pages 48-51.

[15] *See* Application Section 17, page 131.

c. Expanding GME's programs and positions, i.e., residency training programs and positions in specialty care including but not limited to psychiatry;

RESPONSE: The New Health System is committing to investing $85 million dollars over the next decade in research and academics. Where and how these funds are invested is not yet determined. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs will require a collaborative plan to be developed with the academic partners.

d. Helicopter transport services, which are critical given the distance to major health centers. How will Southwest Virginia continue to utilize the free service provided by the Virginia State Police helicopter and staffed currently by Wellmont medical providers? Does New Health System commit to providing financial support of Med Flight? Please describe the plan for integration of Wings, Wellmont One and Med-flight to assure access to all affected areas. Describe the land transport back up plan for occasions when flying for level 1 trauma is not possible.

RESPONSE: Medical evacuation ("MEDEVAC") helicopter transport is an important component of the Geographic Service Area's regional trauma system. While the detail regarding how the various MEDEVAC programs may integrate with the New Health System has not been determined, the service levels are expected to continue after the merger. Each of Mountain States and Wellmont currently partner with existing MEDEVAC programs to enable this service.

1. Wings Air Rescue IV

Med-Trans provides MEDEVAC services through the Wings Air Rescue program throughout the Commonwealth and the country. Wings Air Rescue IV is the program that provides MEDEVAC helicopter services to Southwest Virginia along with other parts of Western Virginia. Med-Trans provides the aircraft and aviation management functions for Wings Air Rescue IV, and Mountain States provides a medical director and medical flight crews.

2. WellmontOne Air Transport

WellmontOne is based in Northeast Tennessee, with a primary service area in Tennessee and a secondary service area in Southwest Virginia. Wellmont provides the medical flight crews, the medical director and administrative oversight of the program.

3. MedFlight II

MedFlight II is a program run by the Virginia State Police to provide MEDEVAC services to Southwest Virginia.[16] There are six Virginia State Police helicopters owned by the

[16] The Virginia State Police also runs MedFlight I for MEDEVAC services to Eastern Virginia.

Commonwealth that are available for the program. In addition to the helicopters, the Virginia State Police provides pilots and insurance for the program, and Wellmont provides a medical director and medical flight crews through Bristol Regional Medical Center. Authorization of and general funding for the MedFlight II program is provided to the Virginia State Police by the Virginia General Assembly. MedFlight II service is dependent on the participation by the Virginia State Police and is contingent on continued funding from and authorization by the Commonwealth. The New Health System intends to retain at least the current level of overall medical flight crew service for MedFlight II in the region. The New Health System also will continue to advocate with the Virginia State Police and the Virginia General Assembly for the continued allocation of pilots, helicopters and funding for the MedFlight II program.

e. Geriatric care.

RESPONSE: Improving chronic disease identification and management is a key component of the New Health System's commitment to invest $75 million in public health in the next decade in the Geographic Service Area.[17] Additionally, the New Health System has committed to performing physician needs assessment in each community every three years[18] and investing in the recruitment and retention of physicians in the area, preferably by assisting independent physician groups in the identification and employment of new physicians, but also by employing physicians where independent practices cannot or choose not to employ these needed physicians. This includes geriatricians, palliative care physicians, psychiatrists and other sub-specialists and clinicians caring for aging adults. In addition, as the mix of services across hospitals is evaluated for efficiencies, gero-psychiatric day programs and inpatient programs are viable alternative uses for unused bed capacity.

Mountain States and Wellmont independently are already pursuing preferred post-acute networks, including skilled nursing and rehabilitation facilities. These efforts focus on improving quality and care management to reduce unnecessary admissions, readmissions and emergency room use. It is expected that these efforts will continue and expand under the New Health System. A Common Clinical IT Platform for health information, which is outlined in the Application, will enable improved performance in the post-acute handoff and management of the patient, and the systems are expected to align efforts to better manage the patients in the post-acute setting upon conclusion of the merger.

f. The provision of a broader range of services for substance use disorder (SUD) treatment in Virginia, including but not limited to intensive outpatient (IOP), inpatient detox, and residential treatment located in Virginia? Please discuss decision-drivers in making determination of location of services, assuring access to transportation of clients to facilities and services as well as access to medications as may be indicated for medication assisted treatment ("MAT"). Please include staffing framework of such facilities by professionals trained in SUD treatment and related mental health co¬morbidities.

[17] *See* Application Section 13.b, pages 48-51.
[18] *See* Application Section 17, page 131.

RESPONSE: The New Health System has committed to spending at least $140 million over ten years pursuing specialty services, which will include mental health and addiction treatment services.[19] However, specific decisions about the location and staffing of these services have not been made. The Applicants believe that the five broad levels of service intensity described by the American Society of Addiction Medicine (ASAM) Criteria[20] provide an evidence-based model of the continuum of recovery-oriented addiction services for the region. Staffing for these services will be in line with evidence-based best practices and the regulatory and professional practice laws of the Commonwealth.

Even with the New Health System's large investment, it is not expected that all the substance use disorder needs of the region can be met. For this reason, in Virginia the New Health System plans to work closely with the Community Service Boards to determine where gaps exist in the continuum of SUD care and where to prioritize services in the region's communities. The New Health System expects that its investments will leverage existing capacity and infrastructure to expand existing services in the region beyond their current reach and to provide critical missing services.

g. Improving access to medical specialty care in Southwest Virginia, including but not limited to gastroenterology, cardiology, pulmonology, oncology, infectious disease/HIV and hepatitis B and C infection treatment? What is the model or are the decision- drivers in determining when a specialty service is provided by telemedicine or "mobile" provider (visiting from a Tri-Cities hub periodically) or having one or more specialists permanently based in a Southwest Virginia locality?

RESPONSE: Ultimately, decisions related to providing services through local employment or subsidization of an independent physician, community rotation or telemedicine are made by balancing demand against need.

The New Health System has committed to performing physician needs assessment in each community in the Geographic Service Area every three years[21] 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.

Additionally, part of the New Health System's commitment to spending at least $140 million over ten years pursuing additional specialty services will be invested in expanding telemedicine, particularly pediatric telemedicine, in the region.[22] The New Health System plans to utilize both approaches (the recruitment of specialists and the provision of specialty services via telemedicine) to improve access to care. However, no

[19] *See* Application Section 15.a.H, page 94.
[20] *See* http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria.
[21] *See* Application Section 17, page 131.
[22] *See* Application Section 17, page 130.

specific decisions about the establishment of permanent services or the expansion of services via telemedicine have been made.

h. Improving access to recommended screening services by the New Health System? What commitment will the New Health System make to take recommended screening including but not limited to colonoscopy services for colon cancer screening, mammography in particular in counties with no access to mammography services such as (Lee County and Scott County), lung cancer screening and Pap screening to assure access in at least one location in each jurisdiction in the Virginia geographic service area? What specific prevention metrics for the population of Southwest Virginia Health Authority footprint for these procedures will the New Health System commit to achieve so that rates comparable to or better than state and national goals are attained.

RESPONSE: The New Health System plans to target the earlier detection of heart disease, diabetes, suicide and cancer by increasing population screening rates for these diseases, as outlined in the Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. These plans include evidence based screenings for colon cancer, mammography, lung cancer and cervical cancer. HEDIS or HEDIS like metrics will be used to track screening rates and goals will be negotiated with the Virginia Department of Health. The location of screening services will be based on identified need and these services may be facility-based or provided via mobile unit. Details about the implementation of screening services will be decided once the Applicants and the Commonwealth agree on the specific conditions to target.

i. In addition to other prevention and intervention metrics the New Health System may commit to, what specific metrics and timetable to achievement is the New Health System willing to commit to achieve a reduction of tobacco use in Southwest Virginia to national goals, a reduction in Southwest Virginia obesity rates, an increase in Southwest Virginia physical activity rates and a reduction in Southwest Virginia drug poisoning deaths and NAS.

RESPONSE: The New Health System commits to implementing programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and NAS in Southwest Virginia, as outlined in the Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. Suggested short-term and intermediate-term outcome metrics are included in the 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 Virginia Department of Health. In order to make data actionable, new or augmented data collection efforts may be necessary.

The New Health System expects to work collaboratively with the Commonwealth 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.

19. Are any of these facilities Critical Access Hospitals? How does Medicare payment for hospital outpatient services, including clinic services, compare to Medicare payment for nonhospital clinic

services under the physician fee schedule? To the extent that Medicare payment is greater for hospital outpatient sites, at least for now, do the additional costs of maintaining a site as a hospital exceed the benefits of receiving Medicare payment as a hospital? Do any of these sites qualify for 340B drug discounts, and if so, same question.

RESPONSE: Mountain States operates two critical access hospitals - Dickenson Community Hospital located in Clintwood, Virginia, and Johnson County Community Hospital located in Mountain City, Tennessee. Wellmont operates one critical access hospital - Hancock County Hospital located in Sneedville, Tennessee.

Medicare payments for the Parties' hospital outpatient services exceed Medicare payment for non-hospital clinic services under the applicable physician fee schedules. This difference partially covers the additional costs that the hospitals bear for much higher percentages of charity and self-pay patients in their payer mix. Pursuant to federal policy, the benefit of ensuring access which occurs through the use of the reimbursement mechanisms to incentivize the placement of providers in underserved areas benefits the region by ensuring access for the uninsured and underinsured. Thus, the incremental cost of maintaining a site as a hospital-based site does not exceed the benefit of the additional reimbursement.

The 340(b) program allows the qualified hospitals to purchase certain drugs at reduced prices. The hospitals below that qualify for 340(b) drug discounts disproportionately treat the majority of the Applicants' charity or uninsured patients. The 340(b) discounts help these hospitals to somewhat offset the losses incurred for the care of the aforementioned patients. None of the Parties' critical access hospitals qualify for 340(b) drug discounts.

The following Mountain States hospitals qualify for 340(b) drug discounts (in alphabetical order):

1. Franklin Woods Community Hospital
2. Indian Path Medical Center
3. Johnson City Medical Center
4. Norton Community Hospital
5. Russell County Medical Center

The following Wellmont hospitals qualify for 340(b) drug discounts (in alphabetical order):

1. Hawkins County Memorial Hospital
2. Holston Valley Medical Center
3. Lonesome Pine Hospital

QUALITY

The New Health System created by the combination of Mountain States and Wellmont proposes to merge several hospitals over a two state region, essentially creating a "monopoly" for acute hospital care services across the region. For this reason, the Authority believes it is important to accurately address access to quality healthcare and whether the New Health System will lead to an improved quality of care that can be easily accessed by the citizens of Southwest Virginia. The following questions center around how quality of care will be impacted and the measurements used to track and assure quality improvement.

The Application states the Applicants' goals in pursuing the merger are to reduce cost growth, improve the quality of the healthcare services, and access to care, including patient experience of care and to enhance overall community health in the region. The Health Care Quality Working Group questions will focus on access to quality of healthcare services; the assurance of improvement in the quality of healthcare services; and plans to improve the patient experience and community health. The Health Care Quality Working Group of the Authority asks the following:

20. In the most recent (Spring 2016) version of the Leapfrog safety scorecard, no hospitals in either Applicant system scored an "A" in patient safety metrics and several received "C" grades. Please provide specific details of how the New Health System proposes to improve these current measures and to assure consistent quality and safety performance of not only the system but each hospital and facility. Please include how the "A" level patient safety criteria measurements will be put in place, how they will be tracked, and how often the performance will be reported to the State. Will these be used by the New Health System to determine if the merger has resulted in quality and safety improvement and will the New Health System and the Commonwealth use these as separation criteria if no (or insufficient) improvement is made or there is a decrease in patient safety and quality outcomes.

a. Poor communication is an example of one metric to be addressed where the systems are performing poorly. Using this as an example, please provide an example of how the New Health System would address this issue benefiting from a "system-wide" approach and how the improvements of this and the other safety metrics in the Leapfrog safety scorecard and how and where these would be reported.

RESPONSE: Communication is one of the domains of HCAHPs, and has a high correlation with overall satisfaction. If the Board of the New Health System determines that this metric is one that needs improvement, it will be one of the annual priority metrics for the system. Incentive programs within the system will be based on these measures with incentive compensation based on improved results for the priority metrics.[23] Performance under these measures will be provided publicly in the manner the Applicants outlined in the Application. As with any effort, scale and elimination of variation are two key elements to improvement. Standardization of processes throughout the system will enable improvement in targeted metrics. While Leapfrog is one organization measuring hospitals, there are many different organizations covering more than 500 metrics. Payers have priorities which are driven by the organizations they are selected to cover, the federal government has its priorities, and the many commercial organizations which measure quality are also factors. In each case, the New Health System will focus on priorities which consider the demands of each of these groups, and such priorities will be vetted by and reported to the Board of the New Health System.

b. A 50% improvement system-wide in the measures is listed as the goal, however this may not be an acceptable improvement in some areas. How will the New Health System set individual goals for quality improvement in each area, as many must be individually addressed?

[23] Currently 20% of Mountain State's company-wide bonus plan is tied to performance on four HCAHP measures of communications: RN communication, MD communication, Communication w/medications, Discharge instructions.

RESPONSE: On recommendation of the Quality Committee and the Social Responsibility & Population Health Committee, the Board of the New Health System will approve the individual quality improvement goals for the organization. Value based payments by Medicare, Medicaid and large commercial payers, will drive many of the metrics and performance levels the New Health System will be held responsible for, as will agreements under the Cooperative Agreement. The Applicants plan to actively collaborate with the payers and the Commonwealth as the Applicants determine which metrics to prioritize and where to set performance thresholds and goals. The ultimate goal of the organization will be to perform at the top decile level in the relevant measures. Both performance and improvement are factors to consider, depending upon the measure, and both will be elements of the system incentive program.

c. The Application states that the New Health System will utilize a rigorous systematic method for evaluating the merits and adverse effects related to quality, access, and service for patients. What additional quality measures will the New Health System use for the rigorous evaluation and reporting to the state? (These would be beyond those currently required for reporting by Medicaid and Medicare and currently used). Such as Triple Aim? Please specify those quality measures that will be utilized to measure success.

RESPONSE: Mountain States and Wellmont are required to report on hundreds of quality measures under their current contracts with commercial payers, Medicaid and Medicare. Many of these measures are not currently publicly reported. The New Health System plans to participate fully in the Commonwealth's efforts to create a common system performance score recommended by the Lt. Governor's Roundtable on Quality, Payment Reform and HIT and will work to adopt the recommend *Focused Menu of Clinical Quality Measures*. This menu was developed in response to growing concern that Virginia providers are being asked to produce far more CQMs than can be effectively monitored and managed in the provider setting. The Applicants intend for the New Health System to focus on measures which have meaning to patients and which are proven to improve the quality of outcomes. In addition, the Application details other specific quality and other measures that the New Health System will report.[24]

21. The Application stresses the importance of an independent medical practice community to the competitive environment in the region. The trend nationally is for increased employment of physicians by hospitals. The value-based payment world of bundled payments, ACOs, etc., integrated systems are focused and require full cooperation to be efficient.

a. How will the New Health System operate as an integrated system utilizing both employed physicians and maintain some predominately non-employed physicians for their ACO and are there other models that exist that have shown this model succeeds?

RESPONSE: Combined, Wellmont and Mountain States employ approximately 30 percent of the physicians in the region – the majority of these employed physicians are traditionally hospital based or are in difficult to recruit sub-specialties or rural areas.[25]

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[24] *See* Application Section 15.a.A.iv "Quality Reporting," pages 75-80.
[25] *See* Application Exhibits 14.2 (Mountain States Physicians) and 14.3 (Wellmont Physicians).

The Applicants have committed to the "development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System."[26] 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.

The New Health System will support this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. The New Health System will (and both Mountain States and Wellmont currently do) provide recruiting assistance to independent physician practices and in some cases provide income support.

The Applicants agree that federal payment reforms have put significant pressure on independent physicians to move towards employment. But other models exist as an alternative. For example, Mountain States' subsidiary Integrated Solutions Health Network (ISHN) operates an accountable care organization (ACO), AnewCare, with a network of independent and employed physicians governed by a board composed largely of physicians. ISHN provides contracting, credentialing and enrollment, quality improvement, care management and analytics services to the ACO and other entities.

The New Health System intends to 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. Successful models such as Clinically Integrated Networks typically have shared governance among members. The New Health System also expects to provide management support services to independent physicians that will allow these physicians to more easily comply with new regulations and financial pressures without the burden of large investment in capital or staffing in areas such as IT, EHR and clinical protocols.

b. What percent of the physicians of the system are independent practice physicians working in out-patient only practice settings (physicians who do not serve in attending roles for patients who are admitted to acute care facilities or are not employed by the New Health System)? How will quality measures be addressed with these referring independent physicians?

RESPONSE: The Applicants cannot provide the information requested because there is no data readily available to calculate it. The Applicants do not identify physicians as "outpatient only" within any physician referral or allocation tools or designations. In addition, there are physicians who might be considered "outpatient only" for the majority of their practices but who moonlight on occasion in ERs and other hospital-based departments.

The decision to practice independently without a relationship to either Wellmont or Mountain States is appropriately the decision of each physician. In the case of

[26] *See* Application Section 17, page 131.

independent physicians, the professional practices and payers typically set quality expectations and monitor performance. As payers increasingly move towards alternative payment methodologies, such as MACRA for all physicians accepting Medicare, physicians will be incentivized to improve quality. As indicated in Response #21.a above, the New Health System intends to collaborate with physicians in the region, including 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. It is the choice of each physician to participate in these efforts. Approximately 70% of physicians overall in the Geographic Service Area are independent.

c. How are these independent physicians integrated into the decision making process regarding quality of care?

RESPONSE: Each facility in the New Health System will continue to operate its own Medical Executive Committee (MEC), which is comprised of employed and independent physicians elected by the members of the medical staff at each facility. These MECs set the rules and conditions for practice within each hospital. The New Health System has committed to forming a Clinical Council composed of physicians nominated by the local Medical Executive Committees and appointed by the Board. The Clinical Council will provide ongoing guidance on reduction in variation, improved peer review and integration of quality efforts with the organized medical community.[27] Both the Master Affiliation Agreement[28] and the bylaws of the New Health System require the Clinical Council.

Also, as noted above, independent physicians who participate in the ACO AnewCare and future efforts such as a Clinically Integrated Network have input into the quality of care decision-making process through their participation on the boards and board committees that govern these networks.

22. The New Health System suggests that improved clinical information through a common IT platform will lead to higher quality and lower cost delivery of care. The majority of the quality improvement in the document is based on a uniform technology platform across the New Health System. The following questions remain:

a. What is the projected (reasonable) timetable for implementation of the new IT platform across the system?

RESPONSE: If the cooperative agreement 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

[27] *See* Application Section 15.a.A.iii, page 75.
[28] Application Exhibit 4.1, Master Affiliation Agreement, Section 9.05.

high-level timeline for implementation of the Common Clinical IT Platform is attached as **Exhibit 22A** to these Responses.

b. What will the new common IT platform offer in tracking outcomes greater than the current platforms being used by each system?

RESPONSE: **Exhibit 22B** to these Responses contains details about both Parties' plans for the Common Clinical IT Platform, including information about the current system each party is using, plans to convert to the single system, the expected features and benefits of the Common Clinical IT Platform and the expected benefits of the Common Clinical IT Platform to a regional Health Information Exchange ("HIE"). As the Authority notes, the Parties anticipate that the proposed Common Clinical IT Platform will enable the New Health System to provide higher quality and lower cost delivery of care. The 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. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. 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 the New Health System to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

c. How will ambulatory practice platforms within the system and independent practices be included in tracking quality outcomes? The application commits to the clinical services network with independent physician groups to share best practices and efforts and to improve outcomes. If the common IT platform does not extend to these groups, how will the outcomes be tracked?

RESPONSE: As more fully described in **Exhibit 22B** to these Responses, the Common Clinical IT Platform will extend to all participating providers in the New Health System, whether employed or non-employed at any location, thereby enabling these providers to track quality outcomes and best practices. The Parties anticipate that independent providers will participate in a regional HIE with access to enhanced information from the New Health System's Common Clinical IT Platform. The Applicants have committed in the Application to (i) 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, and (ii) participate meaningfully in an HIE open to all community providers. The Parties believe a more robust regional HIE will accomplish these goals. **Exhibit 22C** attached to these Responses contains a description of the Parties' use of HIEs.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in a robust regional HIE ensures that valuable health care data collected within the New

Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to significantly improve the quality of care offered across the region.

d. As the hospital proposes to work with independent physician's groups, what access will these groups have to the new IT platform and to what extent (under Stark laws) will the New Health System be able to assist independent physician groups in gaining the appropriate equipment for access?

RESPONSE: Response #22(c) more fully describes the anticipated relationship between the New Health System's Common Clinical IT Platform and a robust regional HIE. The Parties are not aware that independent physicians would need to change their existing equipment in order to access data under a regional HIE. It has been represented to the Parties that the regional HIE eliminates the need for physicians to acquire any new equipment. To the extent that any regional HIE would require physicians to acquire new equipment to participate, the New Health System would be willing to do its part to enable the acquisitions through any available Stark law safe harbors.

e. As physician communication through medical records is not performing well as a part of the "leap-frog" system how will these criteria be measured in the new common platform? Will they be included in both employed and non-employed practices participating in the system?

RESPONSE: The Parties agree with the Authority that establishing a thriving regional HIE is an important goal for the region in order to improve cross-provider communication of information, and patient outcomes[29], and this is the reason behind the New Health System's commitment to participate meaningfully in an HIE open to community providers in the region.[30] The Parties cannot commit to the measurement of non-employed/independent physicians, as they do not expect to control the practices of independent physicians. However, through participation in initiatives, like the ACO or a potential Clinically Integrated Network, communication of key information will be a key requirement for participation.

f. What outcomes and what measures of improvement are to be reported to the state?

RESPONSE: The New Health System anticipates that all of the data it has committed to report publicly on its website will be reported independently to the State, if the State so desires.[31]

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[29] *See* Update to Blueprint for Health Improvement and Health-Enabled Prosperity approved by the Authority January 7, 2016, Aim 5.0, Goal 5.5 "Increase Health Information Exchange (HIE) in regional health systems serving upper east Tennessee and Southwest Virginia... PS: Implement data sharing between regional health systems, including but not limited to, Wellmont Health System, Mountain States Health Alliance, Veterans Administration System, Holston Medical Group, and Tennessee and Virginia Departments of Health."

[30] *See* Application Section 15.a.A., pages 72-73, and Section 17, page 132.

[31] *See* Application Section 15.a.A (pages 76-80).

g. The report commits to CMS core measures and benchmarking against CMS data. What other quality measures will be tracked on the IT platform to demonstrate quality and improved quality?

RESPONSE: In addition to the CMS core measures, patient satisfaction data, benchmarking data, and high priority measures, the New Health System commits to the extensive public and timely reporting on its website the following[32]:

- Surgical site infection rates for each facility annually
- The 10 most frequent surgical procedures performed (by number of cases) at each ASC in the New Health System annually
- The following information annually by facility, aggregated for the facility across the DRGs that comprise 80% of the discharges from the New Health System 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.

h. If the IT system demonstrates an increase in poor outcomes such as length of stay, mortality rate, readmission, C-sections, infection rates, etc. due to consolidation of services within the New Health System, what is the commitment to and process for unwinding consolidated services or to increase service in the rural area? How will the system address unintended negative consequences to quality as a result of the merger?

RESPONSE: Given the correlation between higher volumes and improved quality,[33] and the substantial commitments of the Applicants to develop common protocols, improved

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[32] *See* Application Section 15.a.A, pages 78-80.

[33] *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 *see* 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. *See Impact of Volume Change Over Time on Trauma Mortality in the United States*, Annals of Surgery Brown, J. B., Rosengart, M. R., Kahn, J. M., Mohan, D., Zuckerbraun, B. S., Billiar, T. R., ... & Sperry, J. L. (2016).. *See Understanding the volume-outcome effect in cardiovascular surgery: the role of failure to rescue,* JAMA Surgery, 149(2), Gonzalez, A. A., Dimick, J. B., Birkmeyer, J. D., & Ghaferi, A. A. (2014), pages 119-123. *See Hospital volume and operative mortality in the modern era,* Annals of surgery, 260(2), Reames, B. N., Ghaferi, A. A., Birkmeyer, J. D., & Dimick, J. B. (2014), page 244.

care coordination and alignment of services across the full spectrum of care, it is unlikely a consolidation of a service would lead to poorer quality. In the unlikely event that consolidation of services was found to result in poorer metrics and outcomes, the New Health System would address the service appropriately and seek to determine the sources and specific reasons behind the poorer metrics and outcomes. The Common Clinical IT Platform will enable the New Health System to analyze data and respond to quality measures (both negative and positive results) in a much more timely way than is currently possible. Any negative quality measures would be analyzed to determine root cause. Once the cause is identified, steps would be taken to address the cause and modify service accordingly to improve results. Each of Mountain States and Wellmont currently use widely accepted processes for performance improvement, such as LEAN, for identification of process issues and causation. The New Health System will continue to utilize a highly organized approach to planning improvements, implementation, checking results and revising improvements as necessary and will have an enhanced system to align care and best practices across facilities.

23. The Applicants propose common credentialing standards at all hospitals located on page 38 of the Application. The proposal is for new repurposed facilities. Please discuss the following questions:

a. How will physicians on staff of each hospital be involved in determining standards for credentialing and privileges?

RESPONSE: Each medical staff is governed by a set of bylaws, and privileging is determined as recommended by the local staff. The Applicants' objective is to ensure that a physician, once credentialed within the New Health System, can practice anywhere within the system. It is important, however, to respect the local governance of each medical staff as it relates to privileging for specific procedures and services based on each physician's training, education, and experience. Such privileging will be handled by the local medical staff leadership and recommended to the New Health System's Board.

b. How will the processes for credentialing differ between rural hospitals and larger facilities including tertiary care?

RESPONSE: As the New Health System moves toward system-wide credentialing, it will rely upon the Clinical Council to provide guidance. The Clinical Council will be composed of practicing physicians throughout the system, as nominated by each organized medical staff's elected leadership. Credentialing and privileging should be considered two separate issues. Each hospital must grant privileges based on the local medical staff's evaluation of each physician's competencies; including his or her training, education, and experience. The physician may enjoy overall privileges to practice in any hospital, but may only provide at each hospital the specific services each medical staff determines he or she is competent to perform. The process for credentialing and granting privileges would be the same in rural and tertiary hospitals, even though physicians in rural hospitals generally practice more broadly than in a hospital which has

more specialties available. Each hospital must determine which physician privileges will be granted to a physician based on the needs in that hospital and the physician's demonstrated training, education, and experience.

c. Will independent as well as employed physicians be involved in determining standards in each facility?

RESPONSE: Yes. Physicians elect their medical executive committees, and physicians make up the credentials committee of each medical staff.

d. Will the new credentialing practices differ from current practice?

RESPONSE: The process for credentialing and granting privileges will continue to follow the standards set forward by the Joint Commission and the Healthcare Facilities Accreditation Program (Osteopathic). The objective will be a single application for the entire New Health System, but privileges will be determined by each hospital based upon each physician's demonstrated training, education, and experience and the needs of the hospital.

e. What process will be used for determining credentialing standards for the ambulatory and non-hospital based practices within the health systems? For employed and independent practices?

RESPONSE: Credentialing for non-hospital based practices is no different than for hospital-based practices. The standards are also the same for all physicians - regardless of whether they are employed or independent. If a doctor does not generally practice in a hospital, his or her hospital privileges may be more consultative rather than active and will depend upon the physician's demonstrated training, education, and experience as determined by the credentialing guidelines.

f. How will the New Health System address the maintenance of separate and independent medical staff functions at each hospital and barriers to the introduction of new initiatives to improve quality?

RESPONSE: The charge of the Clinical Council is to work within the medical staff structure to eliminate unwarranted clinical variation in care. This is best conducted through education and use of evidence-based practices. Peer review, privileging, etc., would continue at each hospital. The New Health System will overlay a process for evidence-based practice and will encourage each MEC to evaluate its standards against the evidence-based practices. If a hospital chose not to pursue a particular evidence-based practice, or to hold itself to the system standards, the Clinical Council and the Board of the New Health System will likely inquire as to why, and attempt to collaborate with the organized medical staff to address the issue.

24. The Application focuses on mostly hospital quality measures which all hospitals are required to track. The New Health System will include additional services, especially in those facilities that are being repurposed. Who and how will the New Health System determine the quality measures for such areas as nursing facilities, home health, and system owned physician practices? What are some of the models proposed?

RESPONSE: Quality and patient experience reporting for Home Health, Hospice and Skilled Nursing Facilities is largely dictated by CMS and the New Health System will make the same commitments regarding the public reporting of this data as it has for hospital services. The New Health System will also publicly report the quality and performance data of its Medicare ACO, AnewCare. Employed physician practices participate in a variety of CMS programs on quality and reporting, which are currently undergoing significant revision under the MACRA. In addition, physician practices report other quality measures under value-based payment arrangements with a variety of commercial payers. On recommendation of its Quality Committee and Social Responsibility & Population Health Committee, the New Health System Board will approve the individual quality improvement goals for the system.

The New Health System plans to participate fully in the Commonwealth's efforts to create a common system performance score recommended by the Lt. Governor's Roundtable on Quality, Payment Reform and Health Information Technology and will work to adopt the recommended Focused Menu of Clinical Quality Measures. This menu was developed in response to growing concern that Virginia providers are being asked to produce far more CQMs than can be effectively monitored and managed in the provider setting.

The Parties also note that the New Health System will be committed to aligning metrics across the integrated system in order to better position itself to participate in value-based contracting with payers.

25. Quality and Access cannot be separated when in the rural setting. The current application provides assurance for maintaining only the tertiary care hospitals in Tennessee. The remaining facilities, all Virginia hospitals, are open within the next 5 years for "re-purposing" according to the Application. For the purpose of assuring quality, the task force believes the following questions must be answered prior to consideration:

a. Will the majority of rural hospitals with acute care beds that currently have an average census of greater than 30 be maintained as hospitals with acute care beds?

RESPONSE: Yes. The Applicants have two hospitals in Virginia that have an average daily census above 30 – Mountain States' Johnston Memorial Hospital and Norton Community Hospital – both of which are acute care hospitals.

b. In repurposing facilities what is the acceptable distance or usual travel time between acute care hospitals for a hospital to be maintained and not repurposed?

RESPONSE: The Alignment Policy will govern decisions regarding repurposing of facilities.[34] There is no general "best practice" definition regarding travel time between acute care hospitals, and acceptable travel times depend upon the specialty. For example, lower travel times for Emergency Services are a primary objective. Therefore, all Emergency Rooms currently operating will remain operational. It is important to note that the repurposing of a facility does not necessarily mean elimination of services in a community. In fact, it may actually result in new services being brought to a community. For instance, if a facility is repurposed due to an overabundance of acute

[34] *See* Application Section 12.b, pages 35-36. The Alignment Policy is attached to the Application as Exhibit 12.1.

care beds in an area which can be consolidated, it is possible that the use of the capacity may be switched to another needed service, like psychiatry, long-term acute care, rehab or other specialty use. Also, and importantly, the New Health System has committed to ongoing physician needs assessments and recruitment, so it should be clear the intent is to provide the appropriate services based on demand and need.

c. Will the rural hospitals with a census of less than 30 beds be repurposed to critical access hospitals or only rehabilitation facilities?

RESPONSE: The Alignment Policy will govern decisions regarding service alignment and consolidation, including repurposing of facilities. Service decisions, including repurposing, will be determined based on community need and the factors set forth in Response #5. While no specific decisions have been made at this time, repurposing may occur in full or in part and may result in a variety of services. Rehabilitation is only one example. See also Response #3.

d. How will the communities be involved in determining which services are to be maintained? Will there be a community needs assessment on current services and what the community identifies as essential services? Will the citizens of the community be a part of the comprehensive needs assessment performed for each community served?

RESPONSE: Not-for-profit health systems are required to perform ongoing community needs assessments, and it is an Internal Revenue Service requirement that community members have significant input into this process.[35] In addition, each Mountain States and Wellmont hospital maintains a local board (of various compositions) which provides input into these assessments. Each hospital will maintain a local board, and it is expected that each board will continue needs assessments. In addition, the Alignment Policy requires thorough analysis of the relevant clinical and financial data, and input from physicians and other clinicians relevant to the service and the facility in question.[36]

e. While the outcomes of some services are of higher quality in larger tertiary care centers (i.e.: trauma), certain services must be maintained for the purpose of patient satisfaction, for patient stabilization, and for quality of care. Specifically, as only the 3 tertiary hospitals are listed to be maintained in Tennessee, how many hospitals will be maintained in Virginia that offer acute care hospital beds beyond critical access?

RESPONSE: As noted in Application Section 15.a.B (page 81) most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins. 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,

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[35] 26 CFR § 1.501(r)-(3).

[36] As noted in the Alignment Policy, the New Health System Board's Integration Committee will have a key role in evaluating and recommending alignment opportunities. The Integration Committee will consist of 10 members: 6 members shall be non-management Directors, two of whom shall be physicians; and 4 members shall be at-large members who are not Directors and who are not otherwise serving on any committees of the Board, and at least two of whom shall be independently practicing physicians.

Dickenson Community Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center. The New Health System commits that all Virginia 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 or new scope of services or repurposing as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. Currently, Mountain States and Wellmont are unable independently to make any such commitment to keep rural institutions open.

It is important to note that state lines are political subdivisions which have little bearing on patient utilization. Although Bristol Regional Medical Center and Holston Valley Medical Center are located just over the border in Tennessee, the reality of patient traffic patterns is that 57.4% percent of the patients at BRMCC in Bristol and 28.4% percent of the patients at Holston Valley Medical Center in Kingsport are from Virginia.[37] Patients being transferred from the New Health System's Johnson County Community Hospital in Mountain City, Tennessee are farther from the closest New Health System tertiary center (Bristol Regional Medical Center in Bristol, Tennessee) than patients from Russell County Medical Center in Lebanon, Virginia.

i. How many emergency rooms will be maintained for stabilization of trauma patients and emergency patients (ie: evaluation for chest pain, shortness of breath, etc.)?

RESPONSE: An emergency room will be maintained in each Virginia community where the New Health System currently operates facilities.

ii. Will cancer care be offered in Virginia?

RESPONSE: Yes.

ii. [sic] Will the current level (or improved) of cardiac care be maintained in Virginia?

RESPONSE: Yes.

iii. Will obstetrics and prenatal care be offered in the same facilities in Virginia?

RESPONSE: Yes.

iv. Are there any hospitals who currently have an average greater than 50 inpatients for their census that will be maintained as an acute care hospital with acute care beds).

[37] Based on FY2015 discharge data.

RESPONSE: Yes. The Parties' only Virginia acute care hospital currently meeting the criteria of an average daily census greater than 50 is Johnston Memorial Hospital, which will be maintained as an acute care hospital.

26. Under the commitments to maintain and build quality healthcare in the system is the commitment by the New Health System to combine the best of both organizations career development programs in order to ensure maximum opportunity for career enhancement and training. Specifically, the Application states that the hallmark initiative enabled by the "merger is that of an enhanced academic medical center" aligned to bring health care benefits to the community. The interpretation of the statement could be read as "one academic health center" which is system wide or to moving all residency positions within the tertiary health systems, or sponsored by one facility. While the new Health System states there has been a reduction in graduate medical education positions, there has been a growth of positions in Virginia. Therefore, the following questions must be answered to inform the state of the plans for the current residencies in Virginia. (Note: Virginia has passed recent legislation for the Commonwealth to fund residency positions due to the lack of graduate medical education in Virginia.) Recognizing the current programs are an important vehicle recently established to maintain and improve upon quality healthcare in a rural region:

RESPONSE: To clarify, both Wellmont and Mountain States view themselves as Academic Health Systems and the New Health System will continue to provide training and graduate medical education throughout the system and the entire Geographic Service Area provided federal and state funding continues.

a. Will the new residency programs and residency positions currently at the Johnson Memorial Hospital be maintained In Virginia?

RESPONSE: Yes, the new residency program and positions at Johnston Memorial Hospital will be maintained in Virginia.

b. Will the family medicine residency program and positions in the Lonesome Pine hospital be maintained or repurposed as a rural track residency?

RESPONSE: The residency programs will be maintained in each community where they are located, and there is no change expected at Lonesome Pine.

c. Will the residency program and positions in the Norton Community Hospital be maintained?

RESPONSE: The residency programs will be maintained in each community where they are located, and there is no change expected at Norton Community Hospital.

d. If any of the above residency programs will not be maintained, will the residency positions be kept in Virginia where there is a shortage of residency positions as compared to graduates.

RESPONSE: Yes, these positions will remain in Virginia.

e. How much of the $85 million dollars is committed to increase residency, add faculty, and to sustain research in Virginia?

RESPONSE: This is not yet determined. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs, will require a collaborative plan to be developed with academic partners.

27. The application outlines the provision of "Enhanced Behavioral Health and Substance Abuse Services". Reflecting a continuum of care as outlined, for example, in ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (2013), which services on the continuum will be added or enhanced and where will the enhanced services be offered in Virginia?

RESPONSE: The Applicants believe that the five broad levels of service intensity described by the American Society of Addiction Medicine (ASAM) Criteria[38] provide an evidence-based model of the continuum of recovery-oriented addiction services for the region. In Virginia, the New Health System plans to work closely with the Community Service Boards to determine where gaps exist in the continuum of care and where to prioritize services in the region's communities. The New Health System expects that its investments will leverage existing capacity and infrastructure to expand existing services in the region beyond their current reach and to provide critical missing services.

28. The application's process for improved quality relies on new Clinical Pathways developed (over 70 stated in the presentation). Will these outcomes be tracked and reported as a measurement of improvement of quality of the merger? Will these be utilized in determining if removal of duplicated services will in fact lead to not only cost efficiency but improved outcomes?

RESPONSE: The Clinical Council will have responsibility for promoting the use of Clinical Pathways throughout the new health system which will be adopted by the Medical Executive Committee of each hospital. The Clinical Council will report on compliance with, and outcomes resulting from, the adoption of these Pathways. It is not expected that a pre and post-merger test on these pathways will be performed as many will be adopted post-merger across the system. Compliance with Clinical Pathways may be one measure of improved outcomes post-consolidation of services, but other measures will be considered such as mortality, infection rates, readmission rates, and so on. Under the Consolidation Policy, the Board Integration Committee will set individual evaluation measures to be reported on a case-by-case basis.

29. The application states the New Health System will establish annual priorities in quality improvement. What is the process to determine these annual priorities for quality measures?

RESPONSE: On recommendation of the Quality Committee and the Social Responsibility & Population Health Committee, the New Health System's Board will approve the individual quality improvement goals for the organization. Value-based payments by Medicare, Medicaid and large commercial payers will drive many of the metrics and performance levels for which the New Health System will be accountable, as will the measures agreed to in the State Agreements. The Applicants plan to actively collaborate with the payers and the

[38] *See* http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria.

Commonwealth as they determine which metrics to prioritize and where to set performance thresholds and goals.

30. The application refers to AHRQ guidelines, how and what AHRQ measures will be utilized to measure quality?

RESPONSE: AHRQ was cited as one source of evidence based guidelines which exist to guide the New Health System's performance. As stated above, the Clinical Council will serve as the primary clearinghouse to promote adoption of best practices working with the local MECs and under the governance of the Board committees on Quality, and Social Responsibility and Population Health.

COST TO PROVIDERS, COSTS TO PAYERS, EMPLOYERS AND PATIENTS, REVENUE ASSUMPTIONS, AND THE ECONOMICS OF THE MERGER

31. Please provide an additional set of financial projections based on the consequences of either Virginia or Tennessee or both agreeing to expand Medicaid as permitted under the ACA.

RESPONSE: The New Health System is unable to provide an additional set of financial projections related to the potential expansion of Medicaid as permitted under the ACA. Currently both Virginia and Tennessee have decided not to expand Medicaid, and it is highly uncertain whether either State will ever do so. In addition, there is no information available on how Medicaid might be expanded in Virginia or Tennessee, what the coverages would consist of, what the payment mechanisms and limitations would be, how much providers would be taxed to finance each State's portion of Medicaid funding, and a number of other key assumptions that would be required to model the potential impact. Thus, the Applicants are not able to provide an additional set of financial projections related to Medicaid expansion.

32. The Authority needs much more detailed information for the assumptions underlying the projected financial data post- merger, including without limitation assumptions and conclusions based on other mergers. The spreadsheets of performance before and after the merger provided in Exhibit 9.1 predict improvements but provide virtually no information on the assumptions behind the numbers presented. The Authority needs to understand the basis for the projections in detail. Among the information sought, is information on severity adjusted cost per discharge, labor cost per discharge and other metrics that can support the projections provided. If any of the Applicant hospitals have been penalized by Medicare quality standards regarding readmissions, etc., please indicate how those issues will be specifically addressed.

RESPONSE: As outlined in Exhibit 9.1 of the Application, FTI Consulting provided a description of the baseline financial model and an explanation of the key drivers and/or assumptions used in this baseline model for the preparation of the combined New Health System income statement. The assumptions apply general industry expectations in accordance with historical performance and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed proprietary or confidential such that either Party would be able to identify the other Party's proprietary information. Please find attached as **Exhibit 32** to these Responses updated outputs from the model that now are in the "Year 1," "Year 2," etc., format. Also, this additional representation of the model has been updated to match the baseline assumption that the Parties entities do not make distributions or retain cash.

Hospital reimbursements have been affected by Medicare value-based programs such as (HCAHPS), readmissions, hospital acquired conditions, bundled payments, MSSP, as well as by other services such as skilled nursing facilities (SNFs), home health, and rehabilitation facilities. CMS just recently announced that physicians will be operating under a new value-based system effective January 1, 2019. Wellmont and Mountain States hospitals have performed very well under most of the Medicare value-based programs to date with the exception of readmissions, with most of the Wellmont and Mountain States hospitals being penalized.

Our region historically has had high readmission rates, and reducing readmissions is a priority. Both Wellmont and Mountain States are working to reduce or eliminate avoidable readmissions and are tracking readmissions through their quality departments. Both are actively engaged with post-acute care providers, including home health, long-term care, and rehabilitation facilities, to create best-practice protocols and metrics. These include effective patient transition care procedures and mutual expectations for care and quality standards which have been shown to reduce readmissions. Each health system has metrics associated with readmissions and ongoing process improvement strategies related to this and other quality areas. Both systems participate on a collaborative basis with CMS and most of the principal payers in value-based arrangements that focus on reduction of readmissions.

33. The preliminary efficiencies financial projections include the projected savings from the synergies provided by the merger in addition to the substantial investments to be made by the merging entities. The investments in long-term assets are shown in the projected amounts for PP&E. Where are the investments that are committed to be made in additional personnel to provide new and expanded medical care shown in the projected financial statements? To the extent they are shown in the income statement under salaries, wages and benefits, does the amount shown include both the benefits from synergies and the additional amounts spent for investments in expanded services? Please explain.

RESPONSE: Based on the FTI Consulting analysis, the New Health System is projected to achieve cost savings in the areas of reduced non-labor spend, enhanced labor productivity and clinical program and facility modifications equating to $366M over the first 5 years of its existence as a merged entity, with annual recurring savings of $121M available after year 5 to reinvest in programs to benefit the communities served. As outlined in the Application, the New Health System intends to use these cost savings for initiatives to improve the health of the population in specific areas of identified need (as determined by the Parties and the State), including the recruitment and retention of personnel to provide new and expanded medical care in the Geographic Service Area. Due to antitrust concerns associated with this merger, the Parties are not able at this time to prepare pro-formas for each potential new or expanded service offered by the New Health System; therefore, the investments in additional personnel and other operating costs are not included in the projected income statement. However, to ensure that the Parties are held accountable for their plans, the Parties have proposed in the Application a commitment to the Commonwealth to develop a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. One currently identified area for future additional personnel is pediatric subspecialists. The Parties have committed to recruit and retain pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment to address the region's need for these sub-specialists. See Response #35.

34. What process, if any, do the Applicants propose for reporting to the Authority and the involved states how actual budgets depart from the projected financial information, as well as for reporting actual performance in comparison to budget? What role do the Applicants anticipate the Authority and the states having in reviewing budgets?

RESPONSE: Currently, the financial performance of each of Wellmont and Mountain States is reported publicly each quarter with annual reports made available at the end of each system's fiscal year. The New Health System intends to continue the same quarterly and annual reporting of its financial performance if the merger is approved.

The Virginia Rules and Regulations Governing Cooperative Agreements require the Department of Health to establish quantitative measures that will be used to evaluate the proposed and continuing benefits of an approved cooperative agreement.[39] The New Health System will be required to report annually to the Commissioner on the extent of the benefits realized and compliance with any terms and conditions set forth in the Applicant's State Agreement.[40] The Parties have proposed certain measures in the Application to be used to evaluate the proposed and continuing benefits of the Cooperative Agreement and expect to be held accountable for those commitments. The Applicants believe the ongoing annual oversight by the Commissioner will provide more than adequate opportunity to evaluate the New Health System's performance and its satisfaction or its commitments. Neither the Virginia statute and regulations nor the Tennessee statute and regulations provide for a review process of the New Health System's budgets by either state or the Authority. The members of the Authority include representatives from organizations that are expected to compete with the New Health System. Establishing a reporting or approval process for the New Health System that involves competitors and organizations with separate fiduciary duties could unnecessarily disadvantage the New Health System in its new competitive environment.

35. Given the 19.3 miles separating Bristol Regional Medical Center in Bristol and Wellmont Holston Valley Medical Center in Kingsport and usual travel time of 27 minutes between the two, will creating two pediatric specialty centers be inefficient? Describe the current situation regarding children receiving specialty services?

RESPONSE: The Parties believe that access to pediatric specialties in geographic proximity to where families live is an essential commitment to improving access to needed health care in the region. Mountain States concluded a community needs assessment for Niswonger Children's Hospital in July, 2015. The Niswonger needs assessment found a demonstrated community need for over a dozen specialties analyzed within the geographic service area served by Niswonger Children's Hospital. While consolidation of some services, like the two Level I trauma centers, may offer improved efficiencies, the efficiency of services must be balanced with access to and need for these services. Based on the Niswonger needs assessment, there is demonstrated need and volume support for two pediatric specialty centers, and the New Health System plans to establish pediatric specialty clinics in both Bristol and Kingsport to address these service gaps.

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[39] 12VAC5-221-100(C).
[40] 12VAC5--221-100(A).

A large number of children in the Geographic Service Area are covered by Medicaid, so it is important to recognize the difficulty many families have with transportation and the impact this has on access to care. Currently, there are very few pediatric specialists available in the rural areas of Southwest Virginia. When pediatric specialists are not available in a local community within the Geographic Service Area, children and their families must currently often travel to Johnson City to seek care. If the type of pediatric specialist the child needs is not available in Johnson City, the child and his or her family frequently must travel more than two hours from Southwest Virginia to the nearest competing children's hospital for treatment. The Applicants believe pediatric centers in Bristol and Kingsport would provide needed central access to these services for the Virginia counties in the Geographic Service Area, with decreased travel time for patients. Based on each location's proximity to Virginia, these access points will be an improvement for residents of Virginia and for those communities in Tennessee in which the specialty centers will be located.

The Parties are committed to enhancing the pediatric specialties available in the Geographic Service Area and have determined that providing pediatric specialty clinics in both Bristol and Kingsport will provide appropriate access for several reasons. First, the Bristol and Kingsport locations are close enough to the Niswonger Children's Hospital (each approximately 25 miles distance) that the pediatricians will be able to more easily access the clinics as they travel to the smaller communities. Second, there are advanced specialists located in Bristol and Kingsport who can provide support and other services to pediatric specialists as needed. Finally, the Parties' goal is to make pediatric specialty care as least disruptive as possible for those children and their families who need it. With easier access, families are more likely to seek care when it is needed. Making the specialty clinics more readily available in Bristol and Kingsport is expected to enhance both timely utilization and access.

36. On page 36 of the Application it states that "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." What does this mean?

RESPONSE: Payers have access to significant utilization and financial data that can be used to identify high cost services and processes. Payers also have access to the cost drivers that drive up premiums and overall costs. The federal government has recently announced that 80% of Medicare payments will be "value-based" by 2018, including the significant reforms underway with how physicians are compensated. The New Health System must have a scalable strategy to shift more toward these mandated value-based arrangements. The strategy involves efforts that encourage an improvement in the health of the population served by the New Health System. Given the payer's superior access to aggregate data, the New Health System anticipates expanded value-based contracts with the payers, which will prioritize a focus by the New Health System on eliminating unnecessary cost drivers to reduce costs and improve overall patient outcomes. The Applicants believe that the greater number of patients served by the New Health System will better position it to enter into additional risk-based contracts with payers, which will lead to better patient outcomes and reduced costs.

As an example, a payer may identify that few children are receiving well-child screenings. Without the payer information, the New Health System would have no way of knowing which

providers are doing a better job than others, nor would the New Health System know why. Under a different and aligned contracting methodology with payers, the Applicants anticipate that payers would focus on a low rate of well-child screenings as a concern, and choose to incentivize the New Health System to improve this metric. The payers would share data with the New Health System on the variation that exists in the marketplace, and the New Health System would work with the associated physicians to improve that metric.

More complex examples of potential risk-based contracting models are global payments for certain surgical procedures and a full risk arrangement. Under a full risk arrangement, which is difficult for Mountain States and Wellmont independently to do on a major scale, an entire population health approach can be taken. For instance, a payer may choose to provide incentives for better management of all patients with certain cancer diagnoses. Practical data, such as time from diagnosis to treatment, may be utilized and incentivized based on improvement in various metrics in order to improve patient outcomes. The New Health System with an expanded regional patient population, can deploy strategies and care models that can reduce variation and costs and also improve outcomes. This full risk model can be used for a variety of diagnoses or procedures to the cost benefit of payers, providers and health benefit to patients. It would be very difficult for each system to do this individually in Southwest Virginia because neither system can achieve the critical mass of potential population necessary to assume full risk under payer arrangements.

37. What would be the role of Virginia, Tennessee or the Authority have in any mediation of payer contract negotiations? What assurances can the Applicants offer that such mediation would be concluded timely?

RESPONSE: In the Application, the New Health System has proposed a mediation process as the means to resolve any and all payer contract negotiations that reach an impasse. Since this is a commitment in the Application and potentially in the State Agreements, the New Health System anticipates that the role of the Commonwealth of Virginia and Tennessee will be to ensure that the New Health System negotiates in good faith. The New Health System is willing to commit to timely resolution of any mediation by committing to complete any such mediation within 180 days. The conduct of the payers is important as well, and the New Health System would expect all payers to negotiate in good faith.

It will be in the best interests of the New Health System to resolve any payer disputes in a timely manner since there are a limited number of payers operating in the Southwest Virginia market and one payer has greater than a 75% commercial market share.

The New Health System's pricing commitments benefit the payers, through both pricing concessions and limits on future pricing growth. The New Health System has proposed that already agreed-upon pricing increases would be decreased by 50% for the first full fiscal year that occurs after one year after closing. This commitment provides a substantial benefit to the payers and consumers, as pricing would go up more if the merger were not approved.

38. There are some predicted savings for payors and patients from reducing admissions and readmissions. This will help the community, patients and payers, but will hurt the hospitals. To what extent, if any, was this reflected in the FTI projected revenue for "out" years?

RESPONSE: The New Health System agrees that reduction in inpatient acute utilization rates will provide a substantial financial benefit to payers and patients, but will result in a significant financial loss to the New Health System.

This issue is one of the core reasons behind the Application and proposed merger, as the inpatient acute care use rates have been declining in the Geographic Service Area and are expected to accelerate their decline. These declining use rates, when combined with negative population trends in Southwest Virginia, signal the need to reduce costs and potentially close hospitals absent the merger. Use rates in the Geographic Service Area are at 124 admissions per 1,000 lives, whereas the national rates in moderately managed markets range from 90-110 admissions per 1,000. If the New Health System experiences the same trends in use rates that are occurring nationally, the additional cost reductions will need to occur. Currently, Wellmont and Mountain States duplicate inpatient acute care services with little or no differentiation in service or value. The merger will allow the New Health System to make diligent, reasoned decisions about unnecessary duplication of capacity, which will result in the New Health System being able to withstand the aforementioned utilization reductions.

The model for the New Health System's financial plan is predicated on some migration of inpatient utilization to outpatient utilization over time.

39. What health care insurance plans and health care insurance products does the New Health System plan to attempt to provide? What specifically will the New Health System do to ensure that the plans and products provided offer a wide range of options to consumers of health care in Virginia costs that see no greater increase than are characteristic of the US market?

RESPONSE: The New Health System does not plan to provide any health insurance plans or products. Mountain States' CrestPoint commercial insurance subsidiary exited the insurance and TPA business as of July 1, 2016. It is the New Health System's intent to contract with all payers in the market as Wellmont and Mountain States do currently. By committing to contract with all payers in the market, the New Health System is making a substantial contribution to ensure choices in both plans and products.

COMPETITION

40. As a general public policy in the United States, duplication is a price that we are willing to pay for increased competition. What is unique or unusual about the service area to make operation under state supervision better here than elsewhere? How do the Applicants distinguish this market from any other where consolidation could presumably reduce duplication and result in economies of scale? Is there any data showing the "optimal" size of a health system for purposes of achieving cost efficiency with the least overhead per unit of service? Can that optimal size be realized in larger or more concentrated markets and not here? The Applicants claim that the Southwest Virginia and Northeast Tennessee region is a unique geographic region that requires a unique solution. The solution proposed is one of less competition and increased governmental oversight. Explain why this is the preferred option and provide examples of how such an approach has been successful in other areas.

RESPONSE: The Virginia General Assembly noted the unique nature of the region when it established the Southwest Virginia Health Authority:

> The General Assembly recognizes that rural communities such as those served by the Authority confront unique challenges in the effort to improve health care outcomes and access to quality health care. It is important to facilitate the provision of quality, cost-efficient medical care to rural patients. The provision of care by local providers is important to enhancing, fostering and creating opportunities that advance health status and provide health-related economic benefits.[41]

Having served the region for many years, Mountain States and Wellmont have observed these unique challenges first-hand. The population of this region lags behind the rest of the State in many health areas with substantial medical, personal and economic costs as a result. The economic opportunities in the region are limited and shrinking, and it becomes even more important to support local economies and industries with healthier workforces. Most of the Parties' hospitals based in Virginia are small, serve as the community's sole provider, and are located a good distance away from other hospitals. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in the Virginia communities of the Geographic Service Area. Given that the demand for inpatient services is declining and all but one of the Parties' Virginia hospitals have an average daily census of 35 or less,[42] the Parties believe that the majority of the Virginia hospitals are at risk for survival without the proposed merger. Each of Mountain States and Wellmont currently support the majority of their Virginia hospitals in order to keep these hospitals open. Most of the Parties' Virginia hospitals were previously owned by not-for-profit or for-profit systems that, due to the increasing downward pricing pressure and reduced utilization of services, chose to end their ownership or affiliation of the hospital and sold the facility to Mountain States or Wellmont, or simply stopped compensating for the operational losses of the hospitals. Without the commitments contained in the Application by the New Health System to keep these hospitals open, the reality exists that few of the Southwest Virginia hospitals could survive, or if they did, would do so with significantly reduced services.

As described, most of the Parties' rural hospitals are not sustainable on their own. However, under the New Health System, these hospitals will be part of a larger locally-governed and state supervised system with more assets and resources. The savings realized from elimination of duplicated services will be able to better support the Virginia hospitals and ensure their survival and will be deployed in supporting investments, services and programs to the benefit of local communities.

In addition, the consolidation of services and resources will produce synergies and savings that will enable the Parties to offer and expand health care services to meet the unique health care needs of the population of Southwest Virginia, including residential addiction recovery services, mobile health crisis management teams, intensive outpatient treatment and addiction resources, and pediatric specialty centers. The Parties have made specific commitments to achieve these critical goals.

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[41] Virginia Code§ 15.2-5368.B.

[42] Johnston Memorial Hospital is the Parties' only Virginia hospital with an average daily census over 35. *See* Applications Tables 5.2 and 5.3 for average daily census data, pages 18-19.

Wellmont thoroughly analyzed and considered proposals to merge with out of market acquirers as part of its alignment options analysis begun in 2014. As described in the Application, the Parties determined that a merger between Wellmont and Mountain States was the best option to create efficiencies that could generate savings for reinvestment in this region, and, under the oversight by the Commonwealth under a Cooperative Agreement, to assure tangible benefits for the communities through enforceable commitments and to protect the public from any potential loss of competition through restrictions on pricing. The proposed merger between Mountain States and Wellmont also has the advantage of satisfying the General Assembly's important mandate to provide "care by local providers" because the New Health System will continue to be a locally-based system with decisions made by local leadership rather than by remote leaders based in other parts of the country. Moreover, this care will be patient-centered, with metrics and accountability.

The Parties believe quality will not diminish under the Cooperative Agreement and that improved access and care coordination provide assurances of sustained or improved quality of care across the spectrum of care. The Parties point to the experience of Mission Health in Asheville as support for this position. 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 its 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.[43]

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.[44] 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.

41. The Applicants claim that the proposed merger will not result in any adverse impact on population health, quality, access, availability or cost to patients or payers. In light of the dramatic reduction in competition within the region, what mechanisms are in place to substantiate these claims? To the extent that the response refers to commitments in the Application (or any additional

[43] http://www.mission-health.org/sites/default/files/document-library/1292_0.pdf
[44] http://www.charlotteobserver.com/news/local/article82726402.html

commitments offered by the Applicants), explain how those commitments mitigate or more than balance the adverse impact from reduced competition.

RESPONSE: The proposed merger will result in the consolidation of some services between the Parties, but it also creates the opportunity to achieve significant cost-savings and other benefits for consumers. Among the consumer and community benefits are specific commitments regarding behavioral health, infant and maternal care, cardiac and other health conditions/behaviors. These commitments include common IT systems and information exchanges to improve access to data and information to improve and align care, access to timely information on patients, and investments in specific programs that will be tracked by agreed-upon metrics. All of these align the delivery system around improved care for patients and developing and placing resources in the best locations. The mechanisms to substantiate these claims are the specific accountability mechanisms and metrics proposed in the Application. The Parties note that these benefits accrue not just to commercially insured patients, but also to the broader population, including uninsured, Medicare and Medicaid, and those served in the community other than patients. The benefits of improved health and reduced costs inure generally and to the State.

In addition, active supervision through the Cooperative Agreement 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. 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 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 now 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.

In order to prevent the New Health System from adversely impacting the population health, quality, access, availability or cost to patients or payers, the Parties have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

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 Commonwealth attesting to compliance, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 Commonwealth attesting to compliance, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 concern is that 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 their payers and Mountain States and their 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 Commonwealth would actively supervise the rate cap implementation, and the New Health System would be required by the Commonwealth to file an annual report attesting to compliance. The Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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,

commitments to achieve 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 anticompetitive pricing, 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 Commonwealth 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 Commonwealth and the public for its quality performance. The Commonwealth will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis.

   The Cooperative Agreement provides a unique mechanism for Wellmont and Mountain States to merge under active state supervision. This structure allows the Commonwealth to replace any reduced competition with regulatory oversight of the New Health System and its compliance with the mutually agreed enforceable commitments and assures that the benefits to the community will outweigh the competitive disadvantages. Ongoing, active supervision by the Commonwealth ensures that the benefits of the merger continue to outweigh any potential disadvantages and

that the Commonwealth's policies underlying the issuance of the Cooperative Agreement are fulfilled.

42. How will the merger impact the private providers?

RESPONSE: The Applicants believe that the merger will have little adverse impact on independent providers, and instead, providers will benefit from access to improved IT and health information exchange. **Table 42** below provides analysis of the merger's impact on various categories of independent providers in the Geographic Service Area.

Table 42 – Impact of Merger on Independent Providers

Provider Type	Impact
Physician in private practice	There will be little, if any, adverse impact on physicians in private practice. The Clinical Council of the New Health System, which will be composed in part of independent, privately practicing physicians, will become a resource for physicians practicing in the community as the New Health System attempts to address priority health issues. The New Health System is committing to conduct physician needs assessments and to conduct recruitment in partnership with existing providers rather than using employment as the "go-to" model. This should reduce the reliance on employment, which is a priority of the independently practicing physician community.
Physicians in private practice and who have contracts with hospitals to provide various services	There will be little impact for such physicians. Based on service needs of hospitals, hospitals will continue to contract for needed services.
Post-Acute Skilled Nursing Facilities	The New Health System will seek to collaborate with those facilities willing to reduce unnecessary readmissions, reduce variation in clinical care, improve outcomes and reduce overall costs.
DME	Will remain competitive. There are multiple DME providers.
Pharmacy	Will remain competitive. There are multiple pharmacy providers.
Outpatient Surgery Centers	A substantial number of the outpatient surgery centers in the service area are 100% owned and controlled by independent physicians or are majority owned by independent physicians. Thus, this service will remain highly competitive.[45]

43. Do the Applicants have any plans to increase materially the percentage of physicians in the community who are employed or affiliated with the New Health System?

[45] *See* Exhibit 14.1D to the Application for additional information about outpatient surgery centers in the Geographic Service Area.

RESPONSE: No, the Parties do not have plans to materially increase the percentage of physicians in the community employed or affiliated with the New Health System. Instead, the Parties' objective is to support the independent practice of medicine.

The Parties believe that the physician employment model will be used by the New Health System only to facilitate bringing needed specialties to rural and underserved areas or when private physician groups do not want to expand or do not exist. Under the proposed merger, the Parties intend to use income guarantees and other mechanisms legally available to help private practices recruit and grow. The Parties also plan to implement a Management Services Organization to help these private practices, should they want or require assistance. In addition, as specified in Sections 14 and 17 of the Application, the New Health System has committed to: not engage in exclusive contracting for physician services, except for hospital-based physicians, not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities, and not prohibit independent physicians from participating in health plans and health networks of their choice.

44. Do the market share numbers in the Application reflect all discharges for patients living in the area, even if from a hospital outside the area, or just discharges for patients at area hospitals?

RESPONSE: Market shares in the Application, except where expressly noted, include all hospitals used by patients living in the Geographic Service Area, even hospitals located outside the area.

45. Which ASC's in the area are single specialty or otherwise limited in the type of surgical services furnished?

RESPONSE: Exhibit 14.1 (Section D) of the Application lists all Ambulatory Surgical Centers ("ASCs") serving the Geographic Service Area. The term ASC encompasses all ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

Outpatient services in the Geographic Service Area, including ASCs, have many independent alternatives, which are identified in Application Exhibit 14.1 and whose locations are shown on maps in Figures 14.1-14.3 of the Application (pages 61-63).

The New Health System will face competition from numerous independent outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement, and the Parties anticipate that the independent providers will continue to operate independently and competitively if the Letter Authorizing Cooperative Agreement is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization. We reference Application Exhibit 14.1 (Section D), which lists each of the ASCs in the Geographic Service Area and identifies those that offer only a single service by their Facility Name (e.g., eye surgery only ASCs, which are all identified by the inclusion of "Eye Surgery Center" in their Facility Names). Most of the ASCs, including the Virginia ASCs, offer multiple services.

46. Notwithstanding outpatient competition, will it not be necessary for a health plan to have the New Health System as a contracting provider? Will that not give the New Health System leverage for outpatient rates? Will the Applicants commit to be willing to contract for inpatient and emergency outpatient hospital services only?

RESPONSE: The New Health System will not acquire anticompetitive leverage from the merger. Large payers are of great importance to the New Health System, and it will be important for it to be included in the payer's network. There are sufficient alternatives that payers will have competitive constraints. Currently, 100% of the principal payers in the New Health System's service area have both Wellmont and Mountain States as contracted providers for inpatient, outpatient, and physician services. Once merged, it is the New Health System's intention to continue to be contracting providers to all principal payers to ensure that all of the region's residents have full access to the New Health System's services. The outpatient and physician market is and will remain highly competitive. In addition, the New Health System's pricing commitments apply to outpatient and physician services rates as well as inpatient rates. Typically, virtually all of the principal payers want to contract for all of Wellmont's and Mountain States' services, and the New Health System assumes that would be the case going forward. If a principal payer wanted to contract for inpatient and emergency hospital services only, and the New Health System was unwilling to do that, that negotiation would be subject to the mediation commitment made as part of the Application.

47. What is the share of hospital services furnished by any other hospital (not an applicant) in the primary service area and the secondary service area of the proposed New Health System? What is the share of physician and attending care furnished by independent physician practitioners, not employed by either applicant or affiliated systems, in the primary service area and the secondary service area?

RESPONSE: The Parties are compiling the information requested and will provide this to the Authority in a subsequent response as soon as possible.

48. Please provide a more thorough description of the competitive environment for the New Health System in the proposed service areas, including:

a. Identification of all services and products likely to be affected, either positively or negatively, by the Cooperative Agreement and the locations of the affected services and products;

RESPONSE: The Parties currently provide inpatient, outpatient, and physician services through a variety of facilities located throughout the service area. Many of these services are provided in rural communities with limited healthcare resources and assets and with substantial healthcare challenges. The communities served are relatively sparsely populated with limited commercial volumes, and substantial shares of government pay and uninsured volumes. The Parties anticipate substantial benefits to the residents of these areas, employers, and payers, including government, from the creation and support of an integrated delivery system with supporting infrastructure and investments, including from the deployment of merger savings and synergies across the areas to the benefit of residents. The Parties will provide under the Cooperative Agreement transparent and clear reporting and accountability for investments and programs, with metrics for tracking. These substantial benefits accrue to the benefit of communities and the Commonwealth. Any negative effects and concerns center on the loss of

current competition between Mountain States' and Wellmont's inpatient services. We believe these are less than might be anticipated for several reasons: (1) the combined system will have incentive to reach agreement with payers to sustain important commercial revenues, which are limited; (2) market shares overstate issues because a large part of market share comes from numerous small hospitals which are not a strong competitive constraint; (3) without the merger, substantial cost pressures will limit the Applicants' ability to lower rates materially; (4) there are numerous benefits unlikely to be accomplished but for the merger, and (5) finally, the specific commitments of the Parties limit adverse outcomes.

b. The Applicants' estimate of their current market shares for services and products and the projected market shares if the Cooperative Agreement is approved; and,

RESPONSE: Please see Application Section 5 (pages 14-21) and the accompany Application Exhibits 5.1 and 5.2 for information previously provided on inpatient market shares, and please see Application Section 14 (pages 54-66) and the accompanying Application Exhibits 14.1 for information previously provided on outpatient market shares.

c. A statement of how competition among health care providers or health facilities will be reduced for the services and products included in the Cooperative Agreement.

RESPONSE: Although the merger will eliminate some competition between the Parties, the cooperative agreement is the mechanism created by the Virginia General Assembly to allow beneficial mergers while ensuring through active state supervision that consumers retain those benefits. Through this statutory authority, the Commonwealth 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 discussed in the Application, combined facilities share for outpatient services[46] 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.[47] The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. We 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 cooperative agreement 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 Commonwealth to actively supervise the merger and ensure that consumers reap the expected benefits of higher-quality, more affordable care from the merger.

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

[46] *See* Application Section 14.c (pages 59-66) and the accompany Exhibits 14.1 (Sections A through E).
[47] *See* Application Exhibit 14.1 (Section E).

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 Cooperative Agreement and be actively supervised by the Commonwealth:

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 Cooperative Agreement.

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 is 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 Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 Commonwealth attesting to compliance once the health information exchange is fully established and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

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 Commonwealth attesting to compliance after the first year after formation of the New Health System and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

The Parties believe that including these commitments in the Cooperative Agreement 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 Commonwealth actively supervise these commitments through annual reporting requirements.

49. For payer contracts without competition in inpatient service, where would Southwest Virginia patient's access inpatient services if agreements are not made with insurers?

RESPONSE: The Parties do not anticipate an inability to reach agreement with payers, given the importance of commercial revenues to the Applicants. It will be in the best interests of the New Health System to resolve any payer disputes in a timely manner since there are a limited number of payers operating in the Southwest Virginia market and one payer has greater than a 75% commercial market share. In the unlikely event that the New Health System is unable to reach agreement with payers, there are inpatient hospitals not affiliated with either Wellmont or Mountain States in Wythe, Tazewell, and Buchanan Counties in Southwest Virginia, for example. In addition, there are other third-party hospitals in Roanoke, Asheville, Boone, Pikeville, Winston-Salem, and Knoxville to which patients regularly travel currently for care, as well as academic medical centers in the region and beyond. The marketplace in the region is particularly dynamic, with patients crossing state lines and traveling beyond the Geographic Service Area to seek care. New Health System's intends to contract with all insurers offering health plans in the Geographic Service Area. The New Health System has proposed a commitment requiring it to mediate if unable to reach agreement with any payer. Both Wellmont and Mountain States have enjoyed long-term relationships with all of the principal payers and anticipate the continuation of these relationships under a cooperative agreement.

50. What will the impact of the proposed merger be on the independent physician community in Virginia? What commitments will the Applicants make to independent physicians in Virginia?

RESPONSE: As outlined in Response #42, the Parties do not believe the proposed merger will adversely impact the independent physician community in the Virginia areas of the Geographic Service Area. The New Health System's commitments to foster and support the continuation of an independent physician community in the Geographic Service Area include those outlined in Sections 14 and 17 of the Application:

Commitments to an independent physician community:

- The New Health System will maintain open medical staff 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 New Health System's Board of Directors.
- The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.
- The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.
- 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.
- The New Health System will commit to participate meaningfully in a health information exchange open to community providers.

LABOR FORCE

51. Please provide more detail on the current staffing and the staffing opportunities in Virginia that the Applicants foresee if the Cooperative Agreement is adopted and if the Cooperative Agreement is not adopted?

RESPONSE: The Parties have made no decisions about the workforce after the merger. Antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate specific staffing plans at this time, but the Parties anticipate that the merger will provide job opportunities.

With the commitments made in the Cooperative Agreement to keep all Virginia hospitals open for at least five years, to reinvest savings achieved through synergies into local, community-based services, and to expand specialty services, the Parties believe there is opportunity to maintain or grow the labor force in Virginia. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in the Virginia communities of the Geographic Service Area. Even in Wise County, where there could possibly be service alignment, the savings generated from the merger will likely allow new services to be added that do not currently exist in the community – thereby creating job opportunities and minimizing any potential negative impact on staffing in Wise.

As stated, the Parties believe that job opportunities will be created in Virginia through the merger. The savings generated by the merger efficiencies will enable the New Health System to make substantial investments in providing new services, which will create jobs. Shifting physical resources and personnel away from unnecessary inpatient services 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.

In addition, the New Health System will develop academic and research programs that attract talent throughout the region in Virginia and Tennessee. The New Health System commits to increase residency and training slots, create new specialty fellowship training opportunities, and add faculty. 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.

Under the Cooperative Agreement, the New Health System is able to make the following commitments its communities – commitments that are not in place or possible if the Cooperative Agreement is not adopted.

Commitments to current workforce:

- 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.
- The New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System.

- 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.

Commitments to workforce development:

- 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 – all critical to sustaining an active and competitive training program.
- With its academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-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 Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

The staffing opportunities for the Parties' Virginia facilities are likely to be much less if the Cooperative Agreement is not adopted. The Parties believe that it will be increasingly difficult to continue supplementing the Virginia rural facilities over the long-term without the savings the proposed merger would create, thereby threatening the existence of the facilities and the jobs at these facilities. Most of the Parties' Virginia rural hospitals currently have an average daily census of thirty patients or less.[48] The populations of the Virginia counties in the Geographic Service Area are declining or stagnant and are expected to continue to do so.[49] Wellmont and Mountain States, along with other providers nationwide, 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 Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant

[48] *See* Tables 5.2 and 5.3 in the Application, pages 18-19.
[49] *See* **Exhibit 1B** to these Responses.

health care challenges.[50] 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 support operating losses and to ensure that inpatient services would remain available at the following Virginia rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Dickenson Community Hospital, Lonesome Pine Hospital and Mountain View Regional Medical Center.

The economic strain on the Parties is serious and must be addressed. In addition to the operating losses of their rural hospitals, Wellmont and Mountain States have accumulated nearly $1.5 billion of debt as a result of supporting redundant costs borne by the market and duplicating services and programming as separate health care systems. The significant ongoing duplication of costs and health care services in the region cannot be sustained with the status quo. 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. 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. However, Historical evidence indicates that a merger with an outside competitor would not yield the commitments to the community and continued job opportunities that the Cooperative Agreement would ensure.

In the current resource-constrained, status-quo environment, the Virginia rural hospitals face an uncertain future and are in peril. 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 job opportunities and the economic vitality of these communities. Without the Cooperative Agreement, the peril will continue.

52. The spreadsheets in Exhibit 9.1 show a reduction of personnel expenses in year one. The text indicates that attrition and other factors will be important drivers for those reductions. Please provide more detail on employee history of voluntary departures and new hires for the two separate systems that would be relevant to the New Health System. Please list opportunities that you have considered in investments for the region that would provide new employment opportunities beyond the direct care services of the New Health System.

RESPONSE: Both Wellmont and Mountain States have a labor turnover rate that exceeds 12% annually. This amounts to a combined average of over 1,900 people per year. The Parties believe that attrition will continue to occur under the New Health System. The Parties are committed to their current workforces, and plan to offer all current employees of Mountain States and Wellmont comparable positions within the New Health System. There will be some initial overlap of positions, but continued attrition will result in reduced personnel expenses over time by not having to sustain redundant positions. The New Health System will reduce workforce duplication, overtime and other premium labor costs. Workforce duplication can be

[50] *See* Application Section 3, pages 4-5; and Application Section 15.a.C, pages 82-83.

reduced in many cases by moving employees into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. 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.

The Parties fully anticipate that job opportunities will be available as a result of the commitments under the Cooperative Agreement to invest in continued and new services. However, the Parties are unable to make specific commitments regarding employment opportunities at this time. Antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate such plans. Based on the commitments made in the Application, however, the Parties anticipate that financial savings resulting from synergies achieved through consolidation and avoiding duplication of services will be available to create alternative or enhanced services and programs that will naturally lead to job opportunities. For example, the New Health System has committed to spend at least $140 million over ten years toward specialty services, such as residential addiction recovery services; mental health services; outpatient treatment and addiction resources for adults, children and adolescents; pediatric sub-specialists and specialty centers and rotating specialty clinics in rural hospitals. These new and expanded services represent opportunities for job growth. In addition, the Parties are committed to maintaining all hospitals as clinical and health care institutions for at least five years. This commitment will help to ensure job retention. Therefore, the Parties believe that the commitments made under the proposed merger will provide for new employment opportunities in the future.

53. The projected budget for the New Health System shows $40 million less in labor cost at the end of the 5 year period compared to the existing status projected forward. How many jobs does that represent? How many of those jobs will be at Virginia sites? What steps do the Applicants propose to take to mitigate the effect of job loss on the persons involved and the families and communities affected? We note that one of the problems with the market is low-income and poverty, and the conditions often associated with poverty including, for example, drug abuse. While reducing aggregate jobs may be necessary to achieve savings, it can work at cross purposes to the objectives of the proposed merger which is why we seek your explanation and commitments on how you will mitigate the effects of job loss.

RESPONSE: The Parties are not able to provide numbers and plans for specific labor saving measures at specific hospitals and facilities at this time because antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate such plans. As noted in Section 13.c.2 of the Application, to date, the Parties have identified broad areas of potential labor savings, primarily in overlapping corporate support infrastructure, such as administration, finance and accounting, health information management, human resources, and supply. There is less overlap of corporate support in Virginia. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in Virginia. In Virginia, the Parties anticipate that any negative impact on jobs is minimized under the Cooperative Agreement through: (i) the commitment to maintain all existing hospitals as clinical and health care institutions for at least five years, (ii) the presence of less duplication of jobs and services, (iii) the job opportunities created with new service offerings that the New Health

System will be able to offer under the Cooperative Agreement, and (iv) the natural attrition of the labor force over time.

As the Application outlines, one of the most significant anticipated benefits of the proposed merger is to generate savings through consolidation of duplicated support services as well as duplicated patient services, particularly in areas with lower demand. The resulting savings would provide the necessary financial resources required to create alternative or enhanced services and programs that better meet the current health care needs and demands of the Southwest Virginia region. This reinvestment would help retain existing jobs and even help create new jobs for these new services. The population would benefit from greater access to services that will better meet their health care needs, including more behavioral health and addiction treatment services. The Cooperative Agreement will enable the Parties through savings resulting from combined synergies to expand health care services in a geographic region in which the larger trends are shifting away from expansion.

In addition, the New Health System has committed to make investments in research and academic initiatives that will benefit the region. The New Health System has committed to:

- With academic partners in Virginia and Tennessee, develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.

- Work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

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.

The Parties do not believe that the Cooperative Agreement will contribute to the economic decline of the region. Quite the contrary. The overall health and economic well-being of our communities will benefit from the retained jobs made possible by keeping existing facilities open under the Cooperative Agreement along with the health improvement and job opportunities created by expanded and new services and the increased opportunity for third-party investment in the region.

54. To what extent do the Applicants see new jobs being created in Virginia through the committed "investments?" Please be specific.

RESPONSE: As noted in Response #53 above, the proposed merger will allow the Parties to avoid duplication of services and generate important savings. Mountain States and Wellmont have committed to utilize resulting savings from the consolidation to invest in the health care of the region, specifically targeting investment in those health care services that best meet the current health care needs of the population in the region. The Parties have committed to spending at least $140 million over 10 years pursuing specialty services, which otherwise could

not be sustainable in the region without the financial support offered by the New Health System. Specifically, the New Health System will:

- 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 commitments under the Cooperative Agreement will enable the New Health System to minimize job losses and to better allocate services and resources within the Geographic Service Area to meet the needs of the communities served. The New Health System's investment in these new and expanded services would lead to job opportunity and improved health.

The Parties are not yet able to identify the specific new services and programs that will be offered and supported by the New Health System or to provide any additional detail because (i) antitrust laws prohibit discussion between the Parties of information needed to formulate such detailed plans and (ii) the Parties expect that the Commonwealth will contribute to the Parties' determination of specific services and targeted health care needs of the region's population.

55. How will decisions be made about the Virginia workforce following the merger? How will decisions be made about the Virginia workforce if the Cooperative Agreement is not approved? This question is not just who will make the decision but what criteria the decision-makers will use.

RESPONSE: The Parties have made no decisions about the Virginia workforce following the merger. The primary consideration for any decision to be made by the New Health System after the merger will be the health care needs of the population served in the Geographic Service Area. As a result, the workforce of the New Health System will be aligned to provide services to best meet these patient needs. In making service decisions, the New Health System will consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders, and demonstrated community need for a service; availability of qualified, experienced personnel; unnecessary duplication of services that are readily available but not being utilized to capacity; impact on patient travel times for services; resource requirements to provide the service; balancing the commitment of resources among all needed services; and obligations of the New Health System under the State Agreements. In each case, the weighting of factors will depend upon the circumstances in that community.

All decisions relating to changes in services and workforce will be consistent with the Alignment Policy and made by the leadership of the New Health System, which will consist of executives from communities in the region. Although the Alignment Policy is general at this time because of the Parties' constraints under antitrust laws in sharing detailed operational data, the Parties have established the basic principles that will be applied in the Alignment Policy which will result

in decisions about health care services and the attendant effects on the workforce being made by the locally-based leadership of the New Health System.

The Parties believe that the Cooperative Agreement will ensure that decisions about the region's workforce will be made by people who are part of the communities affected. In contrast, if the Cooperative Agreement is not approved, the likely, market-driven result is that the Parties will be forced to merge with larger health systems from outside the region and that decisions that significantly affect the region and its workforce would be made by people who do not live in the affected communities. Through state supervision, the Cooperative Agreement will ensure that the New Health System will achieve the overriding community benefits and the desired efficiencies, cost-savings, and quality enhancement opportunities. The Parties believe that keeping local governance of the region's health care decisions through the Cooperative Agreement is the best way to ensure that the health care needs of the region and its workforce will continue to be key consideration in any health care changes that are made.

COMMITMENTS AND METRICS FOR MEASURING SUCCESS

56. A number of commitments provide for reports. Reports will show monitoring by the states but how does reporting show active supervision? As just one example, there could be an "investment" (whatever that means) that reasonable persons could disagree on whether it was for "community health." Or the investment may be for a service or facility that is not viewed by the states as being a very efficient way to get to the goal of community health. More generally, the Authority does not believe that "reporting," by itself, is a sufficient commitment. For all commitments for which there is "reporting," please advise what the Applicants think should occur if the Authority or Commonwealth do not believe that the substance of what is reported is satisfactory?

RESPONSE: Based on Mountain States' and Wellmont's current understanding of the Cooperative Agreement process, the Parties and the Commonwealth will agree on the following, before the State Agreement is finalized:

- The areas of greatest health care need in the region in order to achieve population health improvement where resources (monetary and other) are to be allocated.
- Specific programs and initiatives that will be most effective in meeting these health care needs and achieving the population health improvement goals.
- The specific commitments (monetary and otherwise) to be made to those programs and initiatives.
- The reporting obligations or other evidence of compliance that the New Health System will have in order to show fulfillment of its commitments.
- The performance metrics and criteria that the Commonwealth will use to evaluate the New Health System's satisfaction of its commitments.

Mountain States and Wellmont anticipate that the Commonwealth will have significant involvement and input in determining the specific programs and initiatives that the Parties will undertake, initially and on an ongoing basis. In the Application, the Parties have identified areas

of health care need that, based on the Authority's goals, the Commonwealth's state health plan, hospital community needs assessments and their own experience and expertise, they believe are critical for population health improvement in the region. The Parties have set forth representative examples of some of the specific commitments they believe can meet these health care needs and have noted that reporting on the commitments will be made. The Parties anticipate that the Commonwealth (with input from the Authority and others it seeks to consult) and the New Health System will identify the most pressing health care needs and priorities of the region and the *specific* commitments that can best meet these needs and the population health improvement goals.

Reporting obligations of the New Health System and the Department of Health's oversight of these commitments will be agreed upon by the Commonwealth and the Parties prospectively in sufficient detail to establish expectations from all involved and will be set forth in the State Agreement. The reporting obligations for each specific commitment may vary. The Parties anticipate that the Commonwealth and the Parties will have input into the specific programs and initiatives toward which the specified monetary commitments will go and in the reporting obligations or other evidence of compliance that will sufficiently demonstrate satisfaction of the commitments.

Mountain States and Wellmont believe there is sufficient precedent that reporting and requiring compliance with commitments will be adequate supervision. For the last twenty years, the State of North Carolina has overseen the Mission Health Certificate of Public Advantage by using annual audits to review the commitments made by Mission and to determine compliance. Based on the success of the Mission Health COPA, the Parties believe that reporting is an effective, generally accepted mechanism for monitoring and enforcing cooperative agreements and COPAs.

The Parties note that the Virginia cooperative agreement statute requires reporting:

> The parties...shall report annually to the Commissioner on the extent of the benefits realized and compliance with other terms and conditions of the approval. The report shall describe the activities conducted pursuant to the cooperative agreement, including any actions taken in furtherance of commitments made by the parties or terms imposed by the Commissioner as a condition for approval of the cooperative agreement, and shall include information relating to price, cost, quality, access to care and population health improvement."[51]

The Parties also expect that the State Agreement will set forth the consequences and remedies that will be required in the event the Commonwealth does not believe the substance of the New Health System's reports is satisfactory. The Virginia cooperative agreement statute provides authority and mechanisms for the Commissioner to ensure commitments are met. The Commissioner may seek additional information and investigate as needed to ensure compliance with the cooperative agreement.[52] Additionally, the Commissioner may initiate a proceeding to determine whether compliance with the cooperative agreement continues to meet the

[51] Virginia Code § 15.2-5384.1(G).
[52] Virginia Code § 15.2-5384.1(G).

requirements of the statute and may seek reasonable modifications to the cooperative agreement to ensure compliance, with the consent of the parties to the agreement.[53]

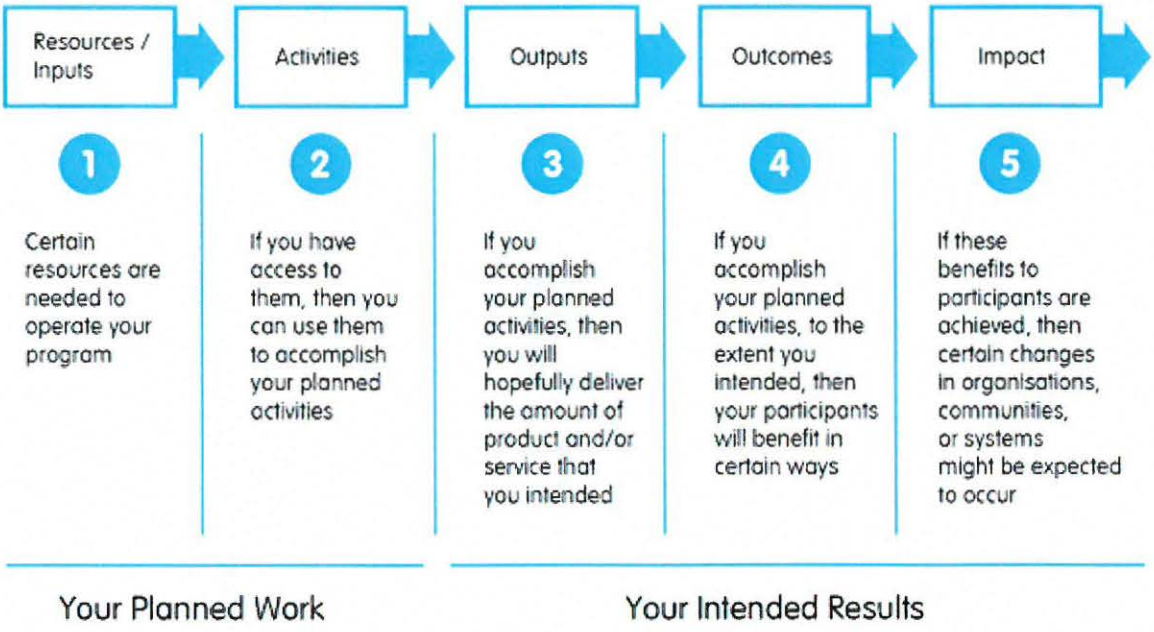
57. The focus of a number of accountability measures is on inputs and not on outcomes or impact. The Authority is much more interested in having specific outcomes as targets against which performance is measured (just as outcomes in patient care are now the focus rather than the costs and inputs). As just one example, moving where local counties rank in drug abuse compared to the state and the nation would be an objective outcome measure.

RESPONSE: The Community Health Improvement Plan (**Exhibit 18** to these Responses) includes short-term and intermediate-term outcomes for population health improvements, which the New Health System hereby submits for consideration by the Authority and the Commonwealth. 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.

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 15.2 of the Application (and included below) for development of the Commitment to Community Health Annual Report Measures.

Figure 15.2 – Logic Model for Evaluation

[53] Virginia Code § 15.2-5384.1(H).



Under this model, the Commonwealth could evaluate progress toward *long-term* community health improvement outcomes under the State Agreement by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The Commonwealth 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).[54]

The root causes of the poor health in the region are many and varied, including many social determinants, so a comprehensive community approach is necessary – no single organization can reverse generational or century long trends that have resulted in one community falling behind another in terms of health, education or the economy. For this reason, the New Health System has committed to provide financial support to develop and sustain an Accountable Care Community,[55] an effort across state lines for the region that will help address these and other issues identified by the Community Health Improvement Plan. The work of the four Community Health Work Groups described in the Application[56] contributed to the development of the New Health System's Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. Establishing a thriving Accountable Care Community is a key component of the Community Health Improvement Plan and will bring together stakeholders from healthcare, public health, education, business, the faith and advocacy communities, government and other sectors to collaboratively and systemically work to achieve long-term health improvement goals for the region.

[54] *See* Application Section 15.d for more detailed description of the proposed accountability measures.
[55] *See* Application Section 15.a.F, page 88.
[56] *See* Application Section 15.a.F, pages 87-91.

58. Will there be a greater commitment than that of achieving 50% of a proposed metric toward a goal? How will achievement be counted across the geographic service area, primary service area, secondary service area, county by county and Tennessee versus Virginia? In the aggregate?

RESPONSE: The Parties will work with the Commonwealth during the Cooperative Agreement review and approval process to determine appropriate metrics for which the New Health System will be held accountable. As noted in Response #56, the Parties anticipate that the final State Agreement will reflect the mutual, prospective understanding of the Commonwealth and the New Health System about the specific commitments the New Health System will make to identified programs and initiatives, the Virginia locations to be affected by such programs and initiatives, the reporting obligations associated with those commitments, and the ways in which the Commonwealth will determine whether the commitments have been satisfied. It is expected that because of current limitations on many state and federal data sources, additional data will need to be collected to report performance metrics at an actionable local level.

Many commitments of the New Health System will encompass the entire Geographic Service Area, while others may focus resources on smaller parts of the Geographic Service Area, which may cross state lines. Different health issues affect different communities in the Geographic Service Area. Part of the Cooperative Agreement review and approval process will be to identify the specific programs and the New Health System's obligations to those programs that the Parties and the Commonwealth believe will most benefit communities. The Virginia and Tennessee State Agreements will set forth reasonable and appropriate metrics for determining satisfaction with the New Health System's progress toward the commitments in the applicable state. The Applicants anticipate that both final State Agreements will reflect a regional approach and commitment from the New Health System befitting the common issues of this geographic area that cross state lines. Although there are similarities with other parts of Virginia and Tennessee, the southern Appalachian mountain region of Southwest Virginia and Northeast Tennessee has a distinct culture, capacity and resource base that results in a unique set of health issues.

In the Application, the Parties have committed to allocate hundreds of millions of dollars over 10 years throughout the Geographic Service Area toward improving the health of this region. The Parties believe this substantial monetary commitment, along with the other commitments set forth in the Application, will be a significant contribution toward the region's and Authority's goal of improving the health of its population.

Without the merger, the Parties will not be able to make these significant contributions to improve the region's health. The merger will generate savings required to allow the New Health System to make meaningful investments toward improving the health of the region's population. These investments could not and would not be made without the merger. As noted in Section 15 of the Application and in Response #55, the likely alternative to the proposed cooperative agreement is a merger by each of the Parties with larger health systems from outside the region. Unlike the proposal by the Parties in the Application with the Cooperative Agreement, a merger with outside health systems would provide no guarantee of investment in the Southwest Virginia region.

In order to evaluate the benefits provided by the New Health System on a continuous basis, the Parties proposed in the Application that the Virginia Department of Health adopt a set of

accountability mechanisms, called "Quantitative Measures," to be used by the Department to evaluate the proposed and continuing benefits of the Cooperative Agreement and the satisfaction by the New Health System of its commitments to the State. The Quantitative Measures proposed were in 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[57]

Because the accountability mechanisms for each category of commitment should and will vary, the Parties outlined their detailed accountability proposal for all categories of the New Health System's commitments. For example, the overall commitment to Improve Community Health encompasses many of the Parties' specific investment and initiative commitments that will improve community health. The Parties proposed accountability measures for each type of commitment and investment to that the Commonwealth will be able to measure yearly and over time how the New Health System is performing in all of these areas. Application Section 15.d details all of the varied and specific Quantitative Measures proposed. The Parties believe its proposal is comprehensive and provides a rational, quantifiable way to measure progress that is difficult to assess.

The population of the Geographic Service Area, as a whole, suffers from poorer health than the rest of the state, which is the result of layered socio-economic dynamics. The Parties believe that the metric achievement percentages proposed in the Application are commensurate with the poor health of the region and the recognition that the commitments made by the New Health System alone will not solve the complex problems contributing to the poor health of the region. The Parties are committed to making substantial investments throughout the Geographic Service Area toward improving the health of the population, but the Parties acknowledge that they cannot alter other forces that also contribute to the health of the region. Therefore, the Parties believe the proposed metric percentages are reasonable.

59. What commitments are the Applicants willing to make to give representation to one or more appointees from the Authority on the New Health System's Board?

RESPONSE: The Parties intend for the New Health System to be operated and governed in ways that are consistent with industry best practices. This includes a board of directors composed of individuals possessing the qualifications and competencies necessary to provide the requisite leadership and expertise critical to a comprehensive health system. The New Health System's board of directors will not have members whose seat on the board is based solely on representation of any group or constituency. All board members of the New Health System will be required to follow the duties required of not-for-profit governing boards. The Parties do not believe these duties are consistent with members whose seats are based solely on representing a particular group or constituency. For these reasons, the Parties cannot make a specific commitment to give representation on the New Health System board to appointee(s) from the Authority or any other group.

[57] *See* Application Section 15.d, pages 98 *et seq*.

60. The Authority notes that the Application has a five-year limit to make sure those duties laid out in the Application are put into action; what will happen following the five-year period? What commitment will the Applicants make to the Authority following the five-year period, for example in years six to ten?

RESPONSE: A substantial number of the commitments made by the Parties cover a ten-year period. For example, the New Health System, as specified in the Application, will commit to spending at least $140 million over ten years pursuing specialty services, including residential addiction recovery services, mobile health crisis management teams, intensive outpatient treatment and addiction resources, and pediatric specialty centers. The New Health System also pledges to commit at least $85 million over ten years to build and sustain research infrastructure, increase residency and training slots, add faculty, and create new specialty fellowship training opportunities. The New Health System also committed at least $75 million over ten years in science and evidence-based population health improvement. The implementation of these commitments will be set forth in the State Agreement, which will be subject to ongoing supervision by the Commonwealth.

In addition, the Commonwealth will have the ability, with its ongoing, active supervision of the State Agreement, to ensure that appropriate commitments continue. As specified in the Virginia cooperative agreement statute, circumstances may dictate that some commitments are modified over time or that committed resources should be allocated in different ways. In the Application, the Parties proposed an initial five-year term for the State Agreement, given that attempts to predict the financial and health care environment beyond the five year period would be difficult. However, as evidenced by the numerous commitments made by the Parties beyond the initial five-year term, the Parties anticipate that the obligations of the New Health System will extend beyond this time. Therefore, Mountain States and Wellmont believe sufficient commitments exist well beyond five years and will continue to exist through the active, ongoing supervision of the State Agreement by the Commonwealth.

OTHER

61. The economy of the catchment area of the New Health System is not strong. There are many studies that link poverty to poor health. The Applicants have made a commitment to improving the health status of the region. Please be more specific about how that commitment will be translated into the reduction of poverty in the community and therefore improvement in health maintenance and prevention.

RESPONSE: As health care providers, both Parties share a similar mission of delivering superior health care and improving the health of patients and the surrounding communities. [58]In the Application, the Parties have committed to allocate hundreds of millions of dollars over 10 years throughout the Geographic Service Area toward improving the health of this region. The Parties believe this significant monetary commitment, along with the other commitments set forth in the Application, will be a substantial contribution toward and force for achieving the Authority's

[58] The mission of Mountain States is to "identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health." The mission of Wellmont is to "deliver superior health care with compassion and a vision to deliver the best health care anywhere."

and the region's goal of improving the health and well-being of its population. The Application identifies several areas that the New Health System would support to promote the well-being of the population, such as ensuring that 3rd graders can read at grade level, reducing the number of low birthweight babies, and confronting the epidemic of addiction, all of which would contribute to greater economic opportunities and well-being for the population.

However, the Parties recognize that the commitments made by the New Health System alone will not solve the "sustained health crises of our region"[59] and that these commitments cannot alter other forces that also contribute to the poor health of the region. The reasons for the poverty and depressed economic condition of the Geographic Service Area are multi-layered and complex. As the Authority noted in the Progress Report 2011 to its Blueprint for Health Improvement and Health-Enabled Prosperity, "...overcoming the substantial health burdens of Southwest Virginia requires a broad, carefully coordinated effort. Importantly, this effort requires an innovative plan that advances educational opportunity and encourages economic development in addition to promoting health."[60] As longtime health care providers in the region, Mountain States and Wellmont have supported this goal and are excited that the proposed merger will allow them to continue to make contributions toward promoting this region's health. The Parties are hopeful that the region's business, education and government sectors, in addition to the health care sector, will also continue to work with the Authority to advance this coordinated effort.

The region's economic stagnation affects the Parties' financial position. The depressed economic conditions of the region and the high percentage of Medicare, Medicaid and uninsured patients mean that the Parties have less money to invest to ensure that inpatient services continue to remain available in the smaller communities of the Geographic Service Area, thereby jeopardizing the sustainability of these services and facilities.

As the Application outlines, one of the most significant anticipated benefits of the proposed merger is to generate savings through consolidation of duplicated services. The resulting savings would provide the financial resources required to reinvest in the region and maintain or expand certain services that would not be economically viable to provide without the benefits of the merger.

62. Will the New Health System be a closed system?

RESPONSE: Both Mountain States and Wellmont currently operate open medical staffs, with exceptions for limited hospital-based services that are customarily excluded from open medical staffs, such as radiology and emergency medicine services. The Parties anticipate that the New Health System would continue to be an open system.

63. What is meant by "investment"? Are investments capital expenditures, start-up expenses of the type that would be amortized, covering operating losses, or simply operating expenses of the new activities? However, defined, using the same definition, how does that compare to present levels of "investment"?

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[59] Southwest Virginia Health Authority Progress Report 2011 to Blueprint for Health Improvement and Health-Enabled Prosperity, page 12.
[60] Progress Report 2011, page 12.

RESPONSE: By "investment," the Parties mean capital expenditures or ongoing operating costs. Such investments are intended to be incremental and constitute additions to current spending costs. The investments to which the Parties have committed are only possible with the savings that the Parties can realize through the proposed merger. Without the proposed merger, financial pressure from factors such as reduced Medicare reimbursement amounts and reduced inpatient utilization may force the Parties individually to decrease current spending amounts and scale back or eliminate services and focus solely on core services. The Parties can make no commitments to "investments" without the merger.

64. What do Medicaid managed care plans think of the proposed transaction?

RESPONSE: The Parties are unable to speak on behalf of Medicaid managed care plans.

65. What is the plan to add residency slots in light of the CMS GME caps? Will GME programs be instituted at hospitals which presently do not have such programs? Are you confident that you will be able to obtain Medicare GME funding? How many residents and in which specialties are you considering, overall and in Virginia?

RESPONSE: Specific plans for and decisions about GME programs and positions have not yet been made. The New Health System intends to continue training and graduate medical education throughout the system and the entire Geographic Service Area, provided federal and state funding continues. This includes the residency programs in the communities where they are currently offered. It is important to note that, prior to the agreement to merge, both health systems independently had begun implementing plans to reduce the number of residency slots. This reduction was halted, in part, because the health systems were committed to deploying synergies related to the merger toward improving, rather than reducing, residency and training programs.

The Parties currently fund more than 60 residency slots that are above the CMS caps. Through the New Health System, the Parties expect to continue the commitment to create additional residency slots. The New Health System will collaborate with educational partners to determine where the need and opportunity for residency slots exist. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs, will require a collaborative plan to be developed with academic partners. Where possible, the New Health System will advocate for and seek to generate federal and state funds to support the needed positions. In the absence of federal and state funds to support needed residency slots, the Parties in the past have had success funding slots through partners. With the merger, the New Health System would also have the ability to continue to support needed residency slots through self-funding if there are inadequate governmental or other funds.

66. If the proposed new services are expected to be profitable, then would not investment be called for now if capital were available? Is capital available--and if the answer is "no," what is the basis for that answer, i.e., advice from investment bankers, debt ratios, or another explanation? If proposed services are not expected to be profitable, that may indicate that there is insufficient demand, although there could be many other reasons for a lack of profitability. Explain why

contemplated non-profitable services, if any, would be added, e.g., meet needs for charity care, improve the community's health status, etc.

RESPONSE: The Parties are unable to predict or guarantee whether the proposed new services will be profitable. Several factors will influence whether proposed services will operate profitably. Some services that the New Health System intends to provide are projected to be non-profitable. For example, expanded pediatric specialties are not likely to be profitable, given that a significant number of the pediatric patients in the Geographic Service Area are covered by Medicaid. For the same reason, mental health services and addiction recovery services are generally not profitable due to the high numbers of the patient population that are covered by Medicaid or uninsured.

Both Mountain States and Wellmont believe that, given the bleak economic environment of the region, their debt service requirements, and existing capital commitments for IT maintenance and other fixed costs, neither Party could individually support investment of comparable amounts to provide such services. The majority of the Parties' available growth capital is devoted to efforts to better compete in the markets of the Geographic Service Area. These efforts create redundant expenditures by the Parties, and the elimination of these efforts will be a source of savings under the proposed merger. Through the merger, more capital will be available for additional investments in needed services whether or not those services prove to be profitable.

67. There are examples of education programs such as nonprofit charter schools housed in health facilities that have improved the academic performance and therefore the opportunity for improved job opportunities for disadvantaged children. You will presumably be redeploying some of the existing infrastructure of the New Health System. Please comment on whether the potential use of those facilities for community needs is being considered? Specifically would you provide comments on any possible plans for early childhood as well as K-8 or K-12 program intervention in the communities you serve?

RESPONSE: The New Health System has committed to working toward the goal of improving the percentage of 3rd graders reading at grade level and has identified nurse family partnership as an evidence based program for improve birth outcomes and which has the additional benefit of improving high school graduation rates in the long-term. The Applicants have not specifically considered redeploying excess facility infrastructure for non-profit charter schools, however, this is not out of the question. The New Health System has committed to funding an Accountable Care Community infrastructure where a group of multi-sector stakeholders work toward common objectives, and discussion of this type would be appropriate in that forum.

68. When closing rural hospitals there is often a loss of rural healthcare workers including physicians, nurses, and others whose employment or level of income is dependent upon the presence of an acute care facility. How will the New Health System evaluate the potential loss of health care workers from the repurposing of hospitals and what measures will be made to assure a physician workforce for that rural region without the presence of an acute care facility? Will the community be actively involved in making this decision including local, county, and city administration?

RESPONSE: Generally, staffing and jobs are based on patient load. Therefore, the threat to health care jobs in the region is not from the merger but from decreased inpatient admissions.

The proposed merger will have little or no effect on this trend. However, the merger will have an impact on the assurance of continued services. The Parties have committed in the Application 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. Without the merger, the Parties are unable to make any guarantee that their hospitals would remain open or any guarantee of continued access to services in the community. The proposed merger provides an enforceable commitment that existing hospitals will remain open for at least five years.

If, after five years, patient need and other factors do not support the continued operation of an existing hospital, the New Health System may decide to repurpose the hospital into another type of facility. Prior to considering potential closures, the most important consideration for the New Health System would be patient need and what is best for patients. However, consideration of the impact on the labor force is something that will be measured. Repurposed hospitals will still require jobs, and many jobs associated with acute care services may still be needed in repurposed facilities. Additionally, as outlined in the Application, the Parties anticipate that savings achieved through the merger will be utilized to create new or expanded services, which will result in additional job opportunities.

All decisions relating to changes in services and workforce will be consistent with the Alignment Policy and made by the leadership of the New Health System, which will consist of executives from communities in the region. In making service decisions, the New Health System will consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders.

LIST OF EXHIBITS

Exhibit Number	Description
Exhibit 1A	Duplication of Services
Exhibit 1B	Southwest Virginia Counties – Inpatient Volume, Population and Inpatient Use Rates
Exhibit 10A	Wythe, Cocke and Hamblen County Hospitals – Utilization by Geographic Service Area Residents
Exhibit 10B	Wythe, Cocke and Hamblen County Residents – Utilization of New Health System Hospitals
Exhibit 11A	75% and 90% Service Areas (Map) Based on New Health System Discharges (Mountain States and Wellmont) 75% and 90% Service Areas (Zip Codes) Based on New Health System Discharges (Mountain States and Wellmont)
Exhibit 11B	75% and 90% Service Areas (Map) Based on Mountain States Discharges Only
Exhibit 11C	75% and 90% Service Areas (Map) Based Wellmont Discharges Only
Exhibit 11D	75% and 90% Service Areas (Zip Codes) for Individual New Health System Hospitals
Exhibit 12A	Inpatient Shares Based on New Health System 75% Service Area
Exhibit 12B	Inpatient Shares Based on New Health System 90% Service Area
Exhibit 12C	Inpatient Shares Based on New Health System's Geographic Service Area
Exhibit 12D	Outpatient Shares Based on New Health System's Estimated 75% Service Area (Excluding Wythe VA, Cocke TN, Hamblen TN, Buchanan VA, Tazewell VA and Hancock TN Counties) Outpatient Shares Based on New Health System's Estimated 90% Service Area (Excluding Wythe VA, Cocke TN and Hamblen TN Counties) Outpatient Shares Based on New Health System's Geographic Service Area
Exhibit 14	Information on Licensed Health Care Professionals (to be provided in a subsequent response)
Exhibit 18	Community Health Improvement Plan

Exhibit Number	Description
Exhibit 22A	High-Level Timeline for Common Clinical IT Platform
Exhibit 22B	Description of Parties Current Electronic Health Records Systems and Plans for Common Clinical IT Platform
Exhibit 22C	Description of the Parties' Use of Health Information Exchanges
Exhibit 32	Updated Financial Projections for New Health System

Exhibit 1A. Duplication of Services Across Mountain States and Wellmont Hospitals

NOTE: Volume equals 25 or more discharges										
System	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA	MSHA
Hospital	Dickenson Community Hospital	Franklin Woods Community Hospital	HealthSouth Quillen Rehabilitation Hospital	Indian Path Medical Center	Johnson City Medical Center	Johnson County Community Hospital	Johnston Memorial Hospital	Norton Community Hospital	Russell County Medical Center	Smyth County Community Hospital
County	Dickenson, VA	Washington, TN	Washington, TN	Sullivan, TN	Washington, TN	Johnson, TN	Washington, VA	Wise, VA	Russell, VA	Smyth, VA
Diagnostic Imaging	X	X		X	X	X	X	X	X	X
Emergency	X	X		X	X	X	X	X	X	X
Inpatient Services	X	X	X	X	X	X	X	X	X	X
Cardiac Surgery					273					
Cardiology		240		464	2,050		627	242	119	167
Cardiology Intervention				217	1,203		150			
Endocrinology		137		270	479		223	65	67	68
ENT Surgery										
Gastroenterology		479		974	1,489		817	138	102	104
General Medicine		457		733	1,965		1,237	280	156	230
General Surgery		356		677	1,173		379	90		37
Gynecology		30		56	123		52			
Hematology		34		112	242		88			
Neonatology		338		194	755		165	47		
Nephrology		260		234	842		485	144	94	99
Neurology		82		174	1,138		300	126	29	43
Neurosurgery				81	529					
OB Deliveries Sections		326		216	330		162	54		
OB Deliveries Vaginal		562		358	740		378	83		
OB Other					179		33	26		
Oncology Medicine		39		27	331		58			
Oncology Surgery		46			59					
Ophthalmic Medicine										
Ophthalmic Surgery										
Oral Surgery					30					
Orthopedic Medicine		35		25	403		87			
Orthopedic Surgery				337	1,364		323	32		77
Otolaryngology		46			94		29			
Plastic Surgery										
Psychiatry					92				478	
Pulmonary		572		549	2,086		939	425	312	275
Rehabilitation			420					47		164
Rheumatology					118					
Substance Abuse		26			139		34			
Thoracic Surgery				28	156					
Trauma Medical					122					
Urology Medicine		104			X		31	25		
Urology Surgery		170		34	50		30			
Vascular Surgery					456		60			

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

Exhibit 1A. Duplication of Services Across Mountain States and Wellmont Hospitals

NOTE: Volume equals 25 or more discharges									
System	MSHA	MSHA	MSHA	Wellmont	Wellmont	Wellmont	Wellmont	Wellmont	Wellmont
Hospital	Sycamore Shoals Hospital	Unicoi County Memorial Hospital, Inc.	Woodridge Psychiatric Hospital	Bristol Regional Medical Center	BRMC Ridgeview Pavilion	LPH/MVRMC	Hancock County Hospital	Hawkins County Memorial Hospital	Holston Valley Medical Center
County	Carter, TN	Unicoi, TN	Washington, TN	Sullivan, TN	Washington, VA	Wise, VA	Hancock, TN	Hawkins, TN	Sullivan, TN
Diagnostic Imaging	X	X		X		X	X	X	X
Emergency	X	X		X		X	X	X	X
Inpatient Services	X	X	X	X	X	X	X	X	X
Cardiac Surgery				231					263
Cardiology	281	51		844		219		114	1,196
Cardiology Intervention				257					683
Endocrinology	153			270		65			328
ENT Surgery									
Gastroenterology	341	79		974		138		56	982
General Medicine	404	82		733		280	28	146	1,048
General Surgery	151			677		90			851
Gynecology				56					141
Hematology	46			112					165
Neonatology				214		48			207
Nephrology	272	49		504		109		59	544
Neurology	112		28	622		36		28	610
Neurosurgery				339					284
OB Deliveries Sections				222		105			268
OB Deliveries Vaginal				427		128			462
OB Other				45		28			45
Oncology Medicine	30			114					130
Oncology Surgery				49					73
Ophthalmic Medicine									
Ophthalmic Surgery						25			
Oral Surgery									
Orthopedic Medicine	28			152					161
Orthopedic Surgery	97			740					1,145
Otolaryngology				26					31
Plastic Surgery				25					26
Psychiatry	154		3,385	820	599				
Pulmonary	663	114		1,291		348	57	185	1,534
Rehabilitation						89		26	
Rheumatology				25					45
Substance Abuse			106	43					26
Thoracic Surgery				57					106
Trauma Medical				42					48
Urology Medicine				45					29
Urology Surgery				84					70
Vascular Surgery				131					257

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

Exhibit 1B. Southwest Virginia Counties – Inpatient Volumes by County and Year

IP Volume	2010	2011	2012	2013	2014	FY 2015
Buchanan County, VA	3,681	3,880	3,692	3,178	3,143	3,118
Dickenson County, VA	2,393	2,456	2,323	1,986	1,928	2,057
Grayson County, VA	1,613	1,596	1,561	1,431	1,468	1,439
Lee County, VA	4,221	4,102	3,419	3,066	2,711	2,561
Russell County, VA	5,075	5,056	4,858	4,434	4,538	4,589
Scott County, VA	3,498	3,492	3,159	3,075	2,969	2,968
Smyth County, VA	4,596	4,849	4,800	4,761	5,122	5,313
Tazewell County, VA	5,317	5,658	5,929	5,284	5,149	5,119
Washington County & Bristol City, VA	10,307	10,739	10,974	9,913	10,349	10,680
Wise County & Norton City, VA	9,726	9,254	8,557	7,913	7,378	7,217
Wythe County, VA	3,965	4,026	4,351	4,137	4,276	4,252

Exhibit 1B. Southwest Virginia Counties - Population by County and Year

Population	2010	2011	2012	2013	2014	2015
Buchanan County, VA	24,040	23,929	23,902	23,647	23,177	22,776
Dickenson County, VA	15,870	15,763	15,670	15,459	15,306	15,115
Grayson County, VA	15,496	15,406	15,225	15,221	15,999	16,012
Lee County, VA	25,532	25,657	25,533	25,187	24,913	24,742
Russell County, VA	28,856	28,652	28,415	28,253	28,012	27,891
Scott County, VA	23,133	22,960	22,790	22,612	22,360	22,126
Smyth County, VA	32,187	32,027	31,873	31,728	31,572	31,470
Tazewell County, VA	45,147	44,677	44,247	44,091	43,436	42,899
Washington County & Bristol City, VA	72,746	72,559	72,867	72,259	72,002	71,732
Wise County & Norton City, VA	45,585	45,442	44,935	44,678	43,975	43,657
Wythe County, VA	29,226	29,185	29,297	29,290	29,060	29,119

Exhibit 1B. Southwest Virginia Counties - Inpatient Use Rates by County and Year

IP Use Rate per 1,000	2010	2011	2012	2013	2014	2015
Buchanan County, VA	153.1	162.1	154.5	134.4	135.6	136.9
Dickenson County, VA	150.8	155.8	148.2	128.5	126.0	136.1
Grayson County, VA	104.1	103.6	102.5	94.0	91.8	89.9
Lee County, VA	165.3	159.9	133.9	121.7	108.8	103.5
Russell County, VA	175.9	176.5	171.0	156.9	162.0	164.5
Scott County, VA	151.2	152.1	138.6	136.0	132.8	134.1
Smyth County, VA	142.8	151.4	150.6	150.1	162.2	168.8
Tazewell County, VA	117.8	126.6	134.0	119.8	118.5	119.3
Washington County & Bristol City, VA	141.7	148.0	150.6	137.2	143.7	148.9
Wise County & Norton City, VA	213.4	203.6	190.4	177.1	167.8	165.3
Wythe County, VA	135.7	137.9	148.5	141.2	147.1	146.0

Exhibit 10A. Wythe, Cocke and Hamblen County Hospitals - Utilization by Geographic Service Area Residents

Hospital	Hospital County	Hospital State	Total Discharges of hospital	Discharges from patients resident in 3 Counties	Discharges from patients resident in rest of GSA	% of Rest of GSA to hospital on table
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	COCKE	TN	2,241	2,000	241	11%
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	HAMBLEN	TN	2,337	1,575	762	33%
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	HAMBLEN	TN	6,419	4,260	2,159	34%
WYTHE COUNTY COMMUNITY HOSPITAL	WYTHE	VA	2,352	1,584	768	33%

Source: CY 2014 State Discharge Data
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 10B. Wythe, Cocke and Hamblen County Residents - Utilization of New Health System Hospitals

Hospital	System	Hospital County	Hospital State	Cocke County, TN	Hamblen County, TN	Wythe County, VA
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	SULLIVAN	TN	26	67	20
SYCAMORE SHOALS HOSPITAL	MSHA	CARTER	TN	1	1	0
INDIAN PATH MEDICAL CENTER	MSHA	SULLIVAN	TN	2	5	4
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	WASHINGTON	TN	2	4	1
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	SULLIVAN	TN	6	8	169
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	HAWKINS	TN	1	25	0
JOHNSON CITY MEDICAL CENTER	MSHA	WASHINGTON	TN	81	66	36
WELLMONT LONESOME PINE HOSPITAL	WHS	WISE	VA	2	0	0
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	SMYTH	VA	0	1	124
NORTON COMMUNITY HOSPITAL	MSHA	NORTON	VA	1	0	1
JOHNSTON MEMORIAL HOSPITAL	MSHA	WASHINGTON	VA	0	0	62
NEWCO Share of County Discharges				**2.4%**	**2.2%**	**12.2%**
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	HAMBLEN	VA	190	1,385	0
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	COCKE	VA	1,925	75	0
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	HAMBLEN	VA	519	3,741	0
WYTHE COUNTY COMMUNITY HOSPITAL	Other	WYTHE	VA	0	0	1,584
OTHER	Other			2,316	2,700	1,416

Source: CY 2014 State Discharge Data
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 11A. 75% and 90% Service Areas (Map) Based on New Health System Discharges (Mountain States + Wellmont)

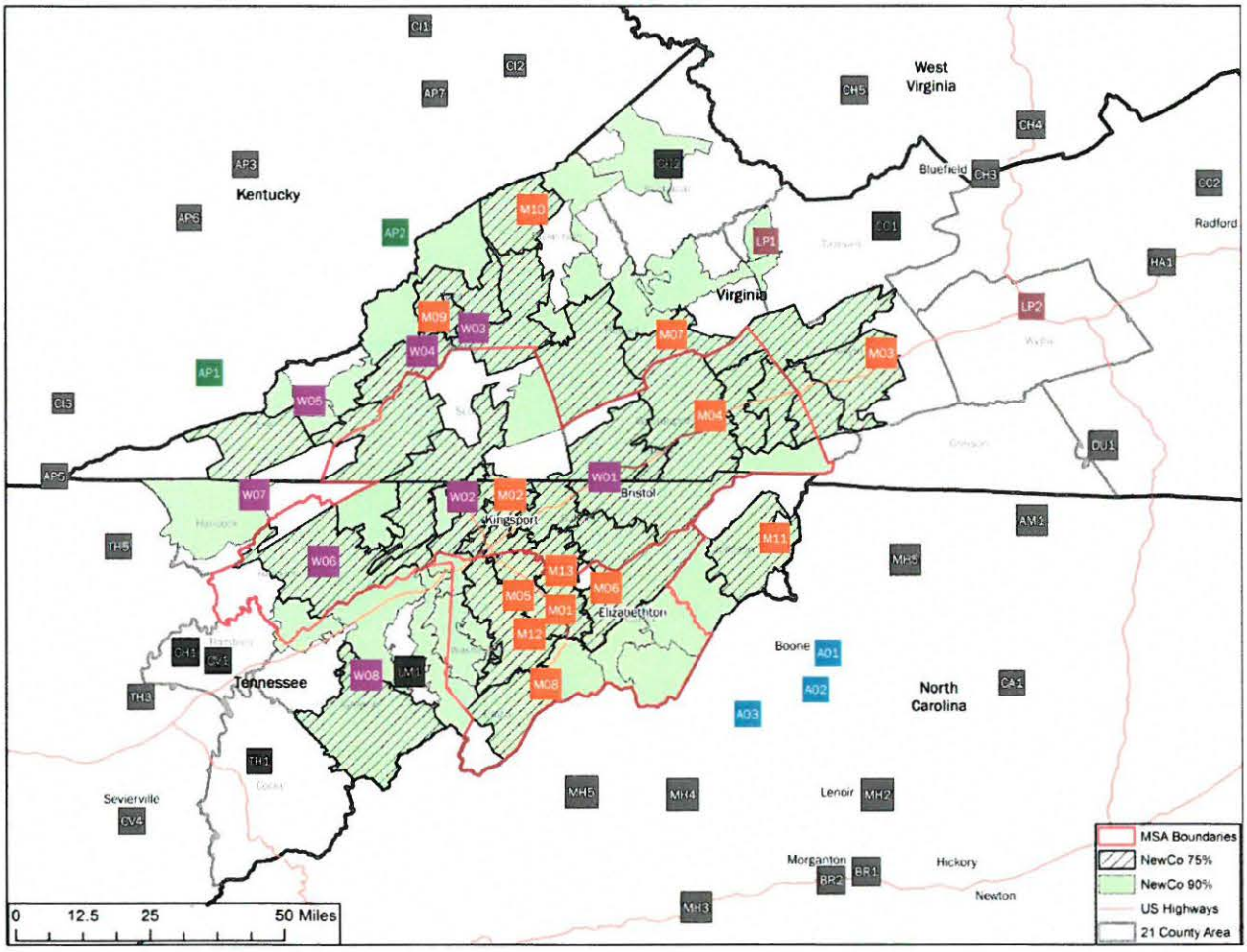

Exhibit 11A. 75% and 90% Service Areas (Zip Codes) Based on New Health System Discharges (Mountain States + Wellmont)

ZIP Code	Discharges	Percentage of Total	Cumulative	75% Service Area	9% Service Area
37660	5,182	5.8%	5.8%	x	x
37601	5,138	5.8%	11.6%	x	x
37643	4,943	5.6%	17.2%	x	x
37620	4,127	4.6%	21.8%	x	x
37604	3,947	4.4%	26.3%	x	x
37659	3,099	3.5%	29.7%	x	x
37664	2,811	3.2%	32.9%	x	x
24210	2,333	2.6%	35.5%	x	x
24201	2,242	2.5%	38.0%	x	x
37857	2,193	2.5%	40.5%	x	x
24354	2,170	2.4%	43.0%	x	x
37650	1,948	2.2%	45.1%	x	x
37615	1,945	2.2%	47.3%	x	x
37642	1,660	1.9%	49.2%	x	x
24219	1,532	1.7%	50.9%	x	x
37617	1,491	1.7%	52.6%	x	x
24293	1,390	1.6%	54.2%	x	x
24202	1,336	1.5%	55.7%	x	x
37683	1,335	1.5%	57.2%	x	x
37618	1,335	1.5%	58.7%	x	x
24266	1,332	1.5%	60.2%	x	x
24230	1,276	1.4%	61.6%	x	x
37663	1,251	1.4%	63.0%	x	x
24211	1,069	1.2%	64.2%	x	x
24273	1,030	1.2%	65.4%	x	x
24251	990	1.1%	66.5%	x	x
24319	985	1.1%	67.6%	x	x
24228	917	1.0%	68.6%	x	x
24370	911	1.0%	69.7%	x	x
37743	895	1.0%	70.7%	x	x
24340	844	0.9%	71.6%	x	x
24244	772	0.9%	72.5%	x	x
24224	749	0.8%	73.3%	x	x
24263	740	0.8%	74.2%	x	x
37686	731	0.8%	75.0%	x	x
24361	684	0.8%	75.7%	x	x
37665	679	0.8%	76.5%		x
24277	675	0.8%	77.3%		x
37692	665	0.7%	78.0%		x
37745	661	0.7%	78.8%		x
24260	660	0.7%	79.5%		x
24279	659	0.7%	80.2%		x
37681	640	0.7%	81.0%		x
37658	613	0.7%	81.7%		x
37687	534	0.6%	82.3%		x
37641	494	0.6%	82.8%		x
37645	491	0.6%	83.4%		x
24236	461	0.5%	83.9%		x
24283	455	0.5%	84.4%		x
37873	449	0.5%	84.9%		x
37690	448	0.5%	85.4%		x
37640	427	0.5%	85.9%		x
24216	411	0.5%	86.3%		x
37869	369	0.4%	86.8%		x
37656	343	0.4%	87.1%		x
24609	322	0.4%	87.5%		x
24243	317	0.4%	87.9%		x
24237	296	0.3%	88.2%		x
24256	277	0.3%	88.5%		x
24271	273	0.3%	88.8%		x
37711	272	0.3%	89.1%		x
24290	245	0.3%	89.4%		x
24614	238	0.3%	89.7%		x
24641	236	0.3%	89.9%		x
24225	230	0.3%	90.2%		x

Exhibit 11B. 75% and 90% Service Areas (Map) Based on Mountain States Discharges Only

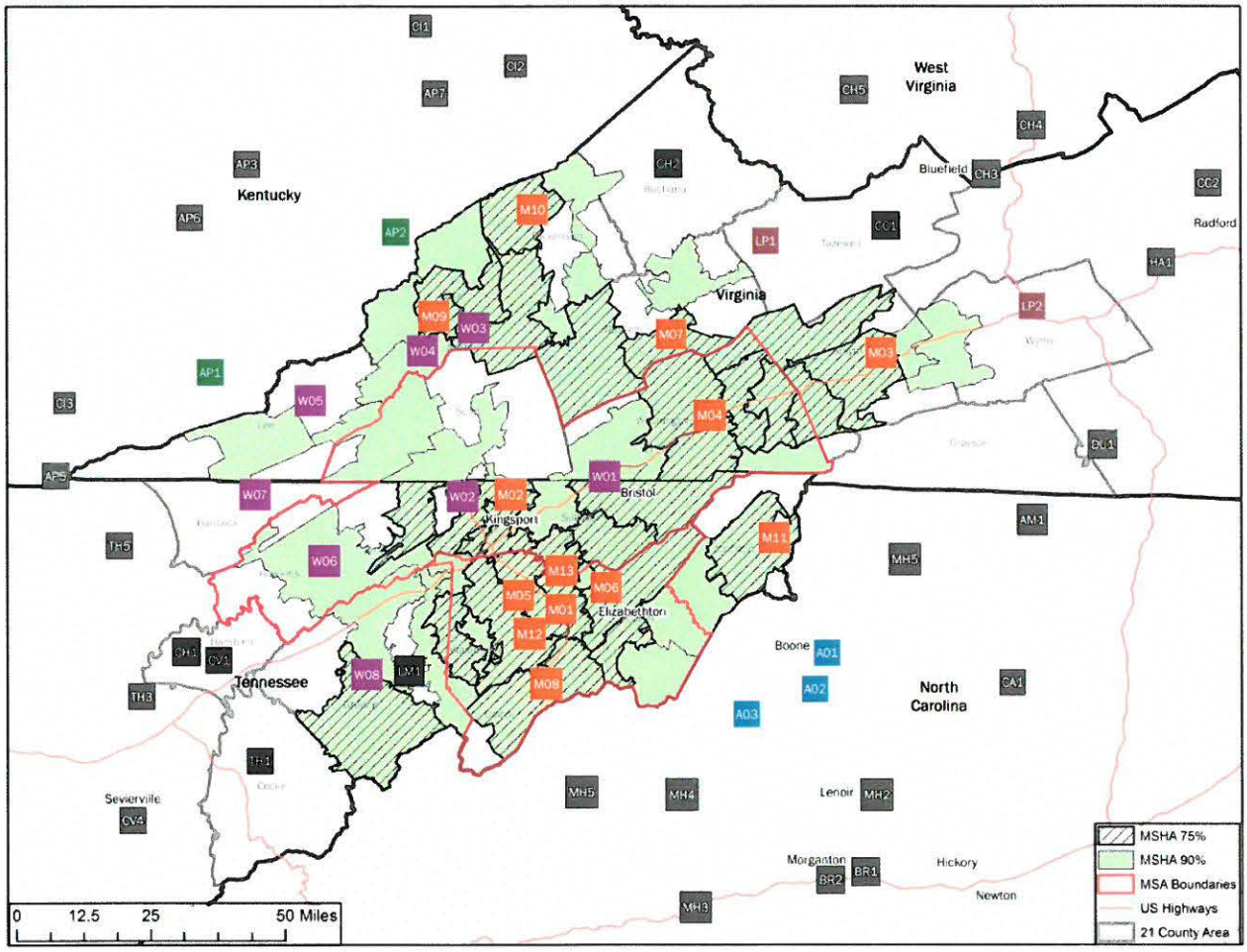

Exhibit 11C. 75% and 90% Service Areas (Map) Based on Wellmont Discharges Only

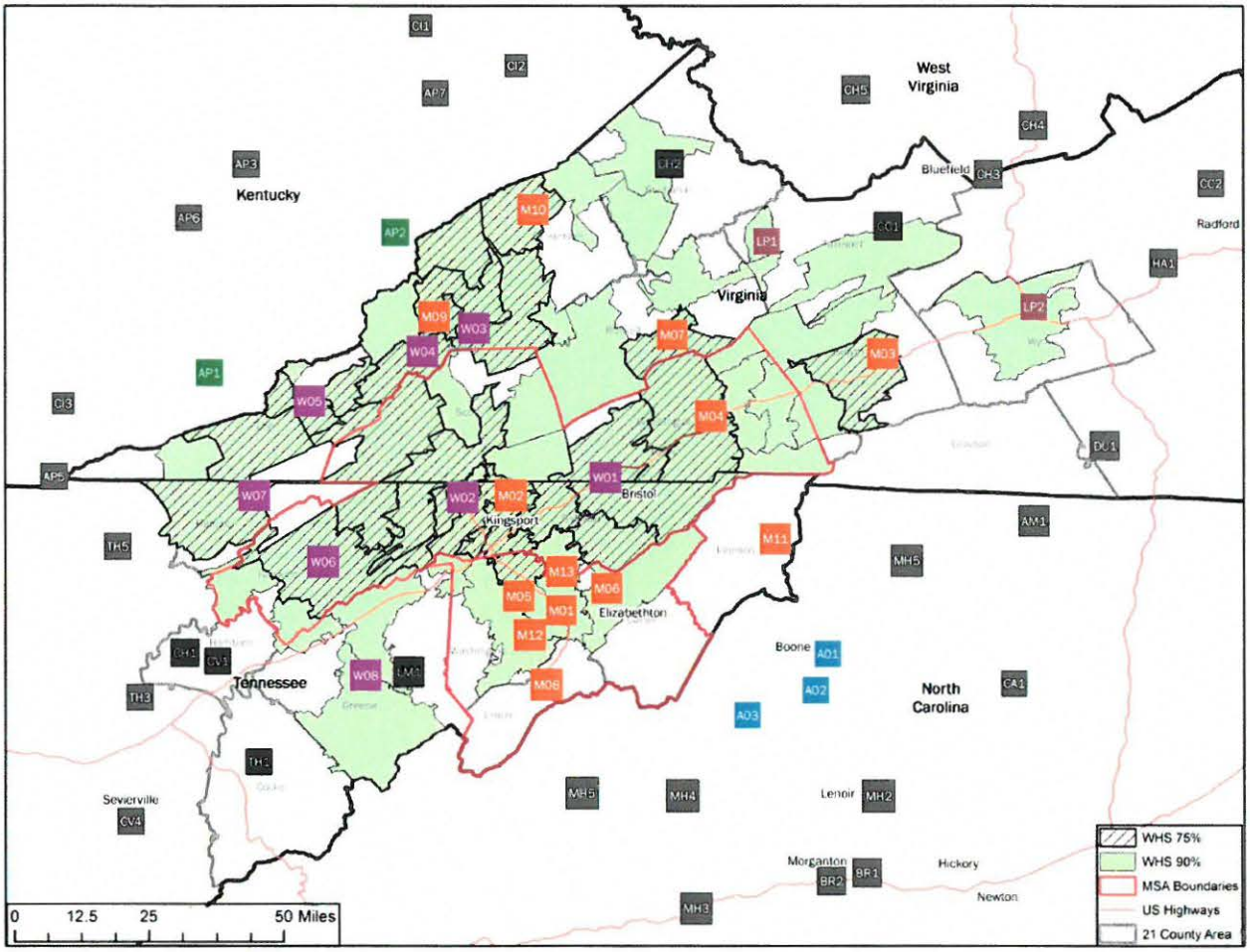

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals

Discharge Area	WELLMONT HOLSTON VALLEY MEDICAL CENTER	WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WELLMONT LONESOME PINE HOSPITAL	MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WELLMONT HANCOCK COUNTY HOSPITAL
ZIPs that make up the 75% Service Area	24219	24201	24216	24219	37711	37869
	24230	24202	24219	24228	37857	
	24244	24210	24230	24230		
	24251	24211	24243	24273		
	24263	24260	24244	24279		
	24271	24266	24263	24293		
	24277	24319	24277			
	24293	24340	24279			
	37615	24354	24293			
	37617	24361				
	37620	24370				
	37642	24609				
	37645	24614				
	37659	37617				
	37660	37618				
	37663	37620				
	37664	37686				
	37665					
	37743					
	37745					
	37857					
	37869					
	37873					
ZIPs that make up the 90% Service Area	24201	24212	24228	24216	37731	24221
	24210	24219	24246	24243	37811	37731
	24216	24224	24265	24244	37873	37765
	24221	24225	24273	24263		37881
	24224	24228	24282	24277		
	24228	24230		24283		
	24243	24236				
	24245	24256				
	24250	24263				
	24258	24273				
	24266	24279				
	24273	24283				
	24279	24293				
	24281	24368				
	24282	24382				
	24283	24620				
	24290	24630				
	24354	24631				
	24614	24637				
	37601	24639				
	37604	24641				
	37618	24649				
	37641	24651				
	37643	24656				
	37650	37615				
	37656	37643				
	37681	37660				
	37686	37663				
	37711	37664				
	37811	37683				
		37857				

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals (Continued)

Discharge Area	JOHNSON CITY MEDICAL CENTER	INDIAN PATH MEDICAL CENTER	JOHNSTON MEMORIAL HOSPITAL	QUILLEN REHAB HOSPITAL	FRANKLIN WOODS COMMUNITY HOSPITAL	WOODRIDGE PSYCHIATRIC HOSPITAL	NORTON COMMUNITY HOSPITAL
ZIPs that make up the 75% Service Area	37601	24228	24201	37601	37601	24251	24219
	37604	24244	24202	37604	37604	37601	24228
	37615	24251	24210	37615	37615	37604	24230
	37618	24263	24211	37643	37643	37615	24256
	37620	24293	24224	37650	37650	37617	24273
	37641	37615	24236	37659	37659	37643	24279
	37643	37617	24266	37681	37686	37659	24293
	37650	37642	24319	37683	37690	37660	
	37658	37645	24340	37692			
	37659	37660	24354	37743			
	37660	37663	24361	37745			
	37681	37664	24370				
	37683	37665					
	37686	37857					
	37690						
	37692						
	37743						
	37745						
ZIPs that make up the 90% Service Area	24201	24219	24212	28657	37618	24266	24216
	24202	24221	24225	28705	37620	24273	24224
	24210	24224	24237	37605	37641	37618	24226
	24211	24230	24260	37616	37658	37641	24237
	24219	24245	24283	37617	37663	37645	24244
	24228	24250	24292	37618	37681	37663	24263
	24230	24258	24311	37620	37683	37664	24272
	24251	24271	24368	37640	37687	37686	24277
	24266	24273	24375	37641	37692		24283
	24273	24277	24609	37644	37743		
	24293	24279	24614	37658	37745		
	24319	24290	24641	37663			
	24354	37620	37620	37686			
	24370	37656	37680	37687			
	28657	37659	37683	37688			
	28705	37873		37690			
	37616						
	37617						
	37640						
	37642						
	37644						
	37656						
	37657						
	37663						
	37664						
	37687						
	37694						
	37818						
	37857						

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals (Continued)

Discharge Area	RUSSELL COUNTY MEDICAL CENTER	SYCAMORE SHOALS HOSPITAL	SMYTH COUNTY COMMUNITY HOSPITAL	DICKENSON COMMUNITY HOSPITAL	UNICOI COUNTY MEMORIAL HOSPITAL, INC.	JOHNSON COUNTY COMMUNITY HOSPITAL
ZIPs that make up the 75% Service Area	24224	37601	24311	24220	37650	37683
	24225	37643	24319	24228	37692	
	24237	37658	24354	24256		
	24260	37683	24370			
	24266					
ZIPs that make up the 90% Service Area	24210	37640	24368		37657	
	24239	37644	24375		37659	
	24280	37687				
	24283	37694				
	24609					
	24646					
	24649					

Exhibit 12A. Inpatient Shares Based on New Health System 75% Service Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Area Discharges	Shares of Wellmont and Mountain States Discharges	Shares of Hospitals in 75% Area
Total		71,881	100.0%		
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	10	0.0%	0.0%	
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	749	1.0%	1.1%	1.1%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	851	1.2%	1.3%	1.2%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,015	1.4%	1.5%	1.5%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	10,700	14.9%	15.9%	15.7%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	12,512	17.4%	18.6%	18.3%
WELLMONT TOTAL	WHS	25,837	35.9%	38.4%	37.8%
DICKENSON COMMUNITY HOSPITAL	MSHA	3	0.0%	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	13	0.0%	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	30	0.0%	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	398	0.6%	0.6%	0.6%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	606	0.8%	0.9%	0.9%
RUSSELL COUNTY MEDICAL CENTER	MSHA	686	1.0%	1.0%	1.0%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,375	1.9%	2.0%	2.0%
NORTON COMMUNITY HOSPITAL	MSHA	2,161	3.0%	3.2%	3.2%
SYCAMORE SHOALS HOSPITAL	MSHA	2,430	3.4%	3.6%	3.6%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	4,377	6.1%	6.5%	6.4%
INDIAN PATH MEDICAL CENTER	MSHA	4,855	6.8%	7.2%	7.1%
JOHNSTON MEMORIAL HOSPITAL	MSHA	6,325	8.8%	9.4%	9.3%
JOHNSON CITY MEDICAL CENTER	MSHA	18,237	25.4%	27.1%	26.7%
MSHA TOTAL	MSHA	41,496	57.7%	61.6%	60.7%
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	1,139	1.6%		
TAKOMA REGIONAL HOSPITAL	Other	1,003	1.4%		1.5%
VANDERBILT UNIVERSITY HOSPITALS	Other	537	0.7%		
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	432	0.6%		
UNIVERSITY OF TENNESSEE MEDICAL CENTER	Other	281	0.4%		
All Other		1,156	1.6%		

Source: CY 2014 State Discharge Data – based on Mountain States and Wellmont Discharges
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 12B. Inpatient Shares Based on New Health System's 90% Service Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Area Discharges	Shares of Wellmont and Mountain States Discharges	Shares of Hospitals in 90% Area
Total		90,650	100.0%		
WELLMONT HANCOCK COUNTY HOSPITAL	WHS	159	0.2%	0.2%	0.2%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	911	1.0%	1.1%	1.0%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,101	1.2%	1.4%	1.3%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,515	1.7%	1.9%	1.7%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	11,735	12.9%	14.6%	13.5%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	15,594	17.2%	19.5%	17.9%
WELLMONT TOTAL	WHS	31,015	34.2%	38.7%	35.6%
DICKENSON COMMUNITY HOSPITAL	MSHA	4	0.0%	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	13	0.0%	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32	0.0%	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	466	0.5%	0.6%	0.5%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	714	0.8%	0.9%	0.8%
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,153	1.3%	1.4%	1.3%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,384	1.5%	1.7%	1.6%
NORTON COMMUNITY HOSPITAL	MSHA	2,873	3.2%	3.6%	3.3%
SYCAMORE SHOALS HOSPITAL	MSHA	2,982	3.3%	3.7%	3.4%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	4,985	5.5%	6.2%	5.7%
INDIAN PATH MEDICAL CENTER	MSHA	5,660	6.2%	7.1%	6.5%
JOHNSTON MEMORIAL HOSPITAL	MSHA	7,273	8.0%	9.1%	8.4%
JOHNSON CITY MEDICAL CENTER	MSHA	21,619	23.8%	27.0%	24.8%
MSHA TOTAL	MSHA	49,158	54.2%	61.3%	56.5%
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	2,598	2.9%		3.0%
CLINCH VALLEY MEDICAL CENTER	Other	1,990	2.2%		2.3%
TAKOMA REGIONAL HOSPITAL	Other	1,736	1.9%		2.0%
VANDERBILT UNIVERSITY HOSPITALS	Other	674	0.7%		
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	612	0.7%		
All Other		2,857	3.2%		0.6%

Source: CY 2014 State Discharge Data – based on Mountain States and Wellmont Discharges
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 12C. Inpatient Shares Based on New Health System's Geographic Service Area

Hospital Name	Hospital Affiliation	Total	Shares of Total Discharges	Shares of WHS and MSHA Discharges
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%
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	WHS	1,012	0.8%	1.2%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	WHS	1,160	1.0%	1.3%
WELLMONT LONESOME PINE HOSPITAL	WHS	1,704	1.4%	2.0%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	WHS	13,000	10.9%	15.0%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	WHS	16,773	14.1%	19.4%
DICKENSON COMMUNITY HOSPITAL	MSHA	5	0.0%	0.0%
JOHNSON COUNTY COMMUNITY HOSPITAL	MSHA	14	0.0%	0.0%
WOODRIDGE PSYCHIATRIC HOSPITAL	MSHA	32	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	MSHA	491	0.4%	0.6%
UNICOI COUNTY MEMORIAL HOSPITAL, INC.	MSHA	757	0.6%	0.9%
RUSSELL COUNTY MEDICAL CENTER	MSHA	1,313	1.1%	1.5%
SMYTH COUNTY COMMUNITY HOSPITAL	MSHA	1,753	1.5%	2.0%
NORTON COMMUNITY HOSPITAL	MSHA	3,120	2.6%	3.6%
SYCAMORE SHOALS HOSPITAL	MSHA	3,167	2.7%	3.7%
FRANKLIN WOODS COMMUNITY HOSPITAL	MSHA	5,138	4.3%	5.9%
INDIAN PATH MEDICAL CENTER	MSHA	5,939	5.0%	6.9%
JOHNSTON MEMORIAL HOSPITAL	MSHA	8,123	6.8%	9.4%
JOHNSON CITY MEDICAL CENTER	MSHA	22,983	19.3%	26.5%
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	543	0.5%	
BUCHANAN GENERAL HOSPITAL	Other	1,041	0.9%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,801	1.5%	
TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL	Other	1,820	1.5%	
TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER	Other	2,011	1.7%	
TAKOMA REGIONAL HOSPITAL	Other	2,270	1.9%	
LAUGHLIN MEMORIAL HOSPITAL, INC.	Other	3,225	2.7%	
CLINCH VALLEY MEDICAL CENTER	Other	4,102	3.4%	
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	4,916	4.1%	
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 12D. Outpatient Shares Based on New Health System's Estimated 75% Service Area (Excluding Wythe, Cocke, Hamblen, Buchanan, Tazewell, and Hancock Counties)

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	2.2%	5	0	0	0	223	**228**
XRAY	28.3%	14	0	12	0	66	**92**
Fitness Center	0.0%	0	0	0	0	67	**67**
Nursing Home	10.9%	3	0	2	0	41	**46**
Physical Therapy	10.8%	1	0	3	0	33	**37**
Home Health	28.6%	8	0	2	0	25	**35**
Rehabilitation	31.4%	4	0	7	0	24	**35**
CT	78.6%	12	0	10	0	6	**28**
MRI	72.0%	11	0	7	0	7	**25**
Urgent Care	72.7%	8	0	8	0	6	**22**
Surgery - Endoscopy	73.7%	9	0	5	0	5	**19**
Surgery - Hospital-based	82.4%	9	0	5	0	3	**17**
Dialysis Services	0.0%	0	0	0	0	15	**15**
Rehabilitation & Physical Therapy	35.7%	0	0	5	0	9	**14**
Chemotherapy	76.9%	4	1	5	0	3	**13**
Wellness Center	23.1%	2	0	1	0	10	**13**
Surgery - ASC	41.7%	2	0	3	3	4	**12**
Radiation Therapy	75.0%	3	0	3	0	2	**8**
Cancer Center	75.0%	3	0	3	0	2	**8**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	3	**3**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**
Cancer Support Services	0.0%	0	0	0	0	1	**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 12D. Outpatient Shares Based on New Health System's Estimated 90% Service Area (Excluding Wythe, Cocke and Hamblen Counties)

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	WHS	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.9%	5	0	0	0	253	258
Fitness Center	0.0%	0	0	0	0	72	72
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	10.2%	3	0	2	0	44	49
Physical Therapy	9.8%	1	0	3	0	37	41
Home Health	22.2%	8	0	2	0	35	45
Rehabilitation	30.6%	4	0	7	0	25	36
CT	68.8%	12	0	10	0	10	32
MRI	62.1%	11	0	7	0	11	29
Surgery - Endoscopy	66.7%	9	0	5	0	7	21
Urgent Care	69.6%	8	0	8	0	7	23
Surgery - Hospital-based	70.0%	9	0	5	0	6	20
Dialysis Services	0.0%	0	0	0	0	16	16
Wellness Center	20.0%	2	0	1	0	12	15
Surgery - ASC	41.7%	2	0	3	4	3	12
Chemotherapy	71.4%	4	1	5	0	4	14
Rehabilitation & Physical Therapy	33.3%	0	0	5	0	10	15
Radiation Therapy	66.7%	3	0	3	0	3	9
Cancer Center	66.7%	3	0	3	0	3	9
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 12D. Outpatient Shares Based on New Health System's Geographic Service Area

Service Type	WHS & MSHA Combined %	Mountain States	Mountain States-NsCH Affiliate	WHS	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 14

Information on Licensed Health Care Professionals

(to be provided in a subsequent response)

Exhibit 18 - 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		
• Increase rates of breastfeeding ▪ Program Example: *Baby Friendly Hospital Initiative*	Increased rate of breastfeeding at 6 months		X	X	X		X
• Increase physical activity ▪ Program Example: *Morning Mile; Project SPARK*	Increased rate of children achieving the recommend level of weekly physical activity		X	X	X		
• Increase healthy eating ▪ Program Example: *#LiveSugarFreed campaign*	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
• Expand anti-smoking campaigns ▪ Program Example: *#UNSMOKABLE*	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
• Decrease diversion ▪ Program Example: *Drug return kiosks*	Milligrams of prescription painkillers removed from circulation					X	X
• Expand anti-opioid campaigns ▪ Program Example: *Above the Influence*	Reduced rate of "ever" tried					X	X
Increase 3rd Graders reading at Grade Level		Increased percentage of 3rd graders scoring "pass/proficient" on VA DOE SOL tests	X	X	X	X	X
• Increase read aloud opportunities ▪ Program Example: *Bear Buddies; Nurse Family Partnership*	Increased percentage of "at-risk" K-2 students paired with a Bear Buddy reading mentor		X	X	X	X	X

Exhibit 18 - 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
• Increase effectiveness of pre-natal care ▪ Program Example: *Nurse Family Partnership; Centering Pregnancy; 17-P utilization*	Increased percentage high-risk women participating in program					X	X
• Decrease tobacco use among pregnant women ▪ Program Example: *ACOG 5 As Behavioral Intervention; Baby and Me*	Increased percentage of pregnant female participants completing nicotine abstinence programs					X	X
• Decrease NAS births ▪ Program Example: *Residential treatment for opioid addicted pregnant women*	Decreased percentage of births with NAS					X	X
• Increase birth spacing ▪ Program Example: *Post-partum LARC insertion*	Increased average/median months between pregnancy in high-risk women					X	X

Exhibit 18 - 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		
• Increase Physical Activity ▪ Program Example: *YMCA Diabetes Prevention Program*	Decreased percentage of adults reporting no physical activity within past month		X	X	X		
• Increase Healthy Eating ▪ Program Example: *YMCA Diabetes Prevention Program*	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
• Increase cessation treatment ▪ Program Example: *Screening and Physician Counseling*	Improved score on tobacco-related HEDIS measures in the New Health System.		X	X	X	X	X
• Expand successful mass-reach health communication interventions ▪ Program Example: *CDC's Tips From Former Smokers*	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
• Increase population screening ▪ Program Example: *Screening and Physician Counseling; SBIRT; Mobile Health Unit Deployment*	Improved score on screening-related HEDIS measures in the New Health System.		X	X	X	X	X

Exhibit 18 - 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
• Decrease prescriptions written ▪ Program Example: *Choosing Wisely, Virginia PMP*	Decreased morphine equivalents prescribed					X	X
Expand Environmental Prevention Strategies		Decreased reported past month non-medical use of pain relievers				X	X
• Increase participation and support of multi-sector community collaborations ▪ Program Example: OneCare	Increased participation in pursuit of select OneCare goals					X	X
Expand supportive services		Decreased reported past month non-medical use of pain relievers				X	X
• Increase supportive housing ▪ Program Example*: Oxford House*	Expanded number of units available in drug-free supportive housing.					X	X

Exhibit 18 - 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	
• Increase use of primary, BH and specialty-care services ▪ Program: *Project Access, Free-clinics*	Increased utilization of primary care and specialty services by High-Need High-Risk population		X	X	X	X	
• Increase use of home-based health services ▪ Program Example: *Community Paramedics, Community Health Workers*	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	
• Increase use of case management ▪ Programs example: *SC Medicaid Healthy Outcomes Program*	Increased percentage of High-Need High Utilizing population in active case management		X	X	X	X	
• Decrease transportation barriers ▪ Programs example: *Transportation vouchers*	Decrease "no-show" rate in High-Need High Utilization population		X	X	X	X	

Exhibit 18 - 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
• Increased screening at sites of care ▪ Program Example: *SBIRT*	Increase in the rates of SBIRT administration					X	X
Reduce Unnecessary Psychiatric Admissions		Decreased psychiatric ER and inpatient admissions.				X	X
• Expand community based outpatient treatment ▪ Program Example: *Assertive Community Treatment*	Increased percentage of individuals with SMI/SUD participating in community-based treatment					X	X
• Expand crisis management services ▪ Program Example: *Mobile Crisis Teams*	Increased percentage of crisis calls responded to by crisis management teams versus law enforcement					X	X
Increase number of individuals with SUD in recovery		Increased percentage of individuals participating in active recovery				X	X
• Expand continuum of treatment options ▪ Program Example: *Medically Monitored Detox, Residential Treatment, Outpatient Treatment*	Increased capacity in full continuum of treatment services for individuals living with SUD					X	X

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

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			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
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												X																												
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											X	X																												
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										X	X	X																												
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									X	X	X	X																												
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												X																												
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													X																												
Data is sent monthly to various analytical companies including Crimson, Comparion and CMS providing statistical analysis for clinical cost, quality, and patient satisfaction for both system and non system providers.																																								

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

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			
Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ii $150 Million Investment																																								
1. Common Clinical IT Platform - $148m * This initiative provides the platform for both the common clinical IT solution and connectivity for health information exchange, population health management and quality measurement reporting. This creates the connected community of hospitals and care givers, providing patients full access to their personal health record.		X	X	X	X	X	X	X	X	X	X	X	X																									
a. Health information exchange - Wellmont's health information exchange plan includes, regional, domestic, and international capabilities. Currently Wellmont is exchanging on all three.														X																									
b. Quality reporting capabilities														X																									
c. Population Health Management														X																									
d. Connectivity for non system providers (current state)														X																									
2. EHR solution for non-system providers $2m*					X																																		
*Cost for the Common Clinical IT Platform will include, but not limited to, the following:																																							
-Hardware: new and upgrades																																							
-Software: new and upgrades																																							
-3rd party interfaces																																							
-Licensing fees																																							
-Post implementation annual maintenance fees																																							
-Vendor implementation fees																																							
-Consulting fees																																							
-Labor																																							
-Training/training related materials																																							
-Go-live support																																							
iii Regional Health Information Exchange	X																																						
Wellmont's participation in OnePartner/HIE will be fully operable June 23, 2016. MSHA is currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange.																																							

Exhibit 22B

- **Description of the Parties' Plans for Electronic Health Records Systems**

A. Wellmont currently uses Epic (2014 version) as its enterprise-wide electronic health record solution. It includes the enterprise system to support the workflows for all clinical areas (acute hospitals and outpatient centers), ambulatory clinics and urgent care centers, as well as the access and revenue system for financial and billing functions. This results in one record for each patient regardless of where he/she is seen within the Wellmont system.

B. Mountain States currently employs multiple Meaningful Use Stage 2 certified technologies to support health care services in the region.

(i) Ambulatory. The ambulatory space is based on the AllScripts Touchworks Electronic Health Record version 11.4.1 hf20 with a planned upgrade to 15.1 scheduled for August 2016. This system supports:

- Problems, Allergy, Medication, and Immunization recoding and communication
- Electronic Medication Prescribing (drug / allergy interaction checking)
- Physician Order Entry
- Physician documentation at point of care
- Electronic lab and radiology resulting
- Electronic document imaging
- Intersystem Communication
- Integrated patient portal supporting scheduling and clinical interaction
- Patient Education

(ii) Acute. Additionally, Mountain States utilizes the Cerner Soarian Version 4.0.15 system for the acute setting. Major functions include:

- Full integrated legal electronic health record
- Problem, allergy, medication, and immunization capture and communication
- Medication administration assurance
- Clinician clinical documentation
- Clinical order entry
- Integration with clinical design and administration (IMRT, Critical Care)
- Digital radiology capture and communication
- Integrated lab result communication
- Intersystem communication

The Ambulatory and Acute systems work as a cohesive unit, supporting all aspects of care across the continuum of Mountain States' integrated healthcare delivery network.

- **Description of plan to convert to a single records system if the New Health System is approved**

  If the Cooperative Agreement 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 22.1** to these Responses. Major categories of the implementation costs would include, but not be limited to, the following:

  (i) Hardware: New and Upgrades
  (ii) Software: New and Upgrades
  (iii) 3rd Party Systems and Interfaces
  (iv) Licensing Fees
  (v) Vendor Implementation Fees
  (vi) Consulting Fees
  (vii) Labor Costs
  (viii) Training/Training Related Materials
  (ix) Go-Live Support
  (x) Post-Implementation Annual Maintenance Fees
  (xi) Any Future Additions of EMR Applications

- **Expected Features and Benefits of the Common Clinical IT Platform.**

  The Common Clinical IT Platform that the New Health System adopts will allow 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. Specifically, the Common Clinical IT Platform is expected to result in a "One Patient-One Record" platform where all health information will be located on one system. The Parties intend for the Common Clinical IT Platform to include the following features:

  A. Log inpatient visits, emergency department visits, outpatient visits, ambulatory clinic visits, urgent care visits, and any visit within the New Health System.
  B. When a physician views a patient record, he/she will be able to see ALL encounters the patient has had anywhere in the system. This will be available to both employed and non-employed physicians.
  C. The data will include all physician notes, nurses notes, therapy notes, all other clinical specialty notes, history/physical, discharge summaries, lab, radiology and other diagnostic reports, allergies, medications, problem lists, radiology images, photos of wounds and other physical notations as surgical photos, all physician

orders placed, protocols used for treatment, patient data from other locations where the patient may have been treated, links to evidence based literature articles as reference and patient education materials.

D. The physician will also be able to link out to past medical records of the patient in the previous EMR system, so he/she does not need to go back to another system to see the patient's history.
E. Future appointments can be made as well as referrals to specialists.
F. Follow up letters to referring physicians can be generated within the Common Clinical IT Platform and sent directly from the Common Clinical IT Platform.
G. Results from outpatient testing will be delivered to the physician's in-basket to allow review of the results as soon as they are completed.
H. Actual radiology/cardiology images can be viewed by the physician within the EMR without going to another system to see the image or to the Radiology Department to view.
I. Patient results can be graphed or charted so trends can be viewed.
J. Data reports can be generated to determine the quality of the care being delivered, which allows for peer review as required by accrediting agencies.
K. Physicians can document the ICD-10 diagnoses with accompanying details for Meaningful Use purposes as required by CMS.
L. Best practice alerts will notify the physician/clinical staff if the patient is at risk for certain issues, medication interactions, falls risk, and numerous other safety features.
M. The order sets will include all orders that are required by CMS and other regulatory agencies as well as best practice guidelines to assure the patient is receiving the best and safest care.
N. Physician notes can be dictated directly into the EMR, saving transcription and reporting time, so the notes are available immediately to any consulting physician or clinical staff.

The 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. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. 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 the New Health System to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

- **Expected Benefits of the Common Clinical IT Platform to the Regional Health Information Exchange (HIE).**

While the Common Clinical IT Platform will offer many benefits to patient care within the New Health System, not all providers in the region will be on the same IT platform as the New Health System and may not be able to share data with the New Health System. Historically, EHRs built by different vendors lacked transmission standards for exchanging patient data between healthcare entities. This meant that many EHR

systems could not exchange data outside of their own private networks. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. Both Mountain States and Wellmont currently participate in an existing HIE in the region, as described below, and the Parties believe the functionality of this HIE or another can be significantly improved through the expanded use of the HIE through the region and the more detailed and meaningful data the New Health System will be able to contribute as a result of its Common Clinical IT Platform. Better communication of patient data and best practices via a thriving regional HIE will improve patient care and lower cost of care. The New Health System is committed to participating meaningfully in the enhancement of a regional HIE.

The Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.

The New Health System desires to support an HIE that will allow the doctors and nurses treating patients in a hospital or doctor's office to access the patient's medical history from any provider connected to the HIE. For example, an independent primary care doctor can review recent lab results whether the test was conducted at an independent specialist's office, at a New Health System hospital, or at a third-party participating lab. Because all authorized doctors and medical personnel will see the same health information through the HIE, this will help to reduce any errors, avoid unneeded duplication of tests and procedures, and consequently, could reduce medical bills.

A key distinction between the Common Clinical IT Platform and HIE is the information available to providers when accessing a medical record. While a provider on the Common Clinical IT Platform will be able to pull up the patient's entire medical history contained in the patient record, the information available within an HIE is typically limited to certain fields that are most commonly used or accessed by providers. This information is typically limited to the following fields:

- 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
- Primary Care Physician
- Custodial/Source Organization

Because the HIE is primarily designed to share information across multiple EHR systems in small and large settings, not all of the Common Clinical IT Platform features are available to providers using the HIE. For example, the Common Clinical IT Platform is expected to include the following features that are not typically included in HIE capabilities:

- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care through evidence-based tools built into the Common Clinical IT Platform
- Improving patient and provider interaction and communication, as well as health care convenience, by enabling electronic communications between providers and patients (e.g. secure messaging)
- Enabling safer, more reliable prescribing by enabling electronic transmission of prescriptions from provider offices to pharmacies
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health
- Enabling providers to improve efficiency and meet their business goals, improve productivity and work-life balance.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in an HIE ensures that the health care data collected within the New Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to drastically improve the quality of care offered across the region.

Exhibit 22C

Description of Parties' Use of Health Information Exchanges

- **Description of the HIEs Currently Used by Each Party**

A. Wellmont

(i) Wellmont is currently an acute data contributor to OnePartner.

(ii) As an acute data contributor, Wellmont provides the following information to OnePartner:
- Demographics
- Encounters
- Labs
- Diagnoses
- Procedures and
- Radiology.

(iii) The initial cost to set up the interface with OnePartner was $63,500.

(iv) There are annual fees of $9,800.

(v) The cost for each provider to be able to access the information in the HIE is $149 per physician per month.

(vi) As of July, 2016, a group of Wellmont physicians have access to OnePartner as collaborators rather than simple contributors.

(vii) The only patient information currently available within the HIE is the 18 data points identified in Subsection C.(vi) below. The patient information can be viewed and printed when the provider is accessing the HIE.

B. Mountain States

(i) Mountain States is currently an acute data contributor to OnePartner under a five year agreement set to expire on December 31, 2019.

(ii) As an acute data contributor, Mountain States provides the following information to OnePartner:
- Demographics
- Encounters
- Labs
- Diagnoses
- Procedures and
- Radiology.

(iii) 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.

(iv) Mountain States Medical Group is currently testing ambulatory data on-boarding with OnePartner, which 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, and Clinical Documents to OnePartner for all patients treated by the Group's 375 providers and mid-levels.

(v) Mountain States' current financial commitment to OnePartner is $98,000, which includes initial setup cost of $53,500 and a contract to pay a participation fee of $8,900 per year for five years for access to the OnePartner data.

(vi) 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 of Mountain States 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.

(vii) 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.

(viii) 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.

(ix) Finally, Mountain States is actively working with Tennessee's Healthcare Innovation Initiative to develop a community case management tool.

C. Description of the OnePartner HIE

(i) OnePartner is a for-profit limited liability company owned by physicians in Northeast Tennessee.

(ii) OnePartner is exclusively a physician regional HIE available to providers located in Northeast Tennessee and Southwest Virginia.

(iii) 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.

(iv) Access to OnePartner is available through an online portal: https://provider.onepartnerhie.com.

(v) 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 approximately $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.

(vi) 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

(vii) These 18 components are sent to the HIE unless a patient affirmatively opts-out and requests that his/her information not be included.

(viii) 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.

(ix) 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.

(x) Based on information provided by OnePartner, the top contributing providers are Mountain States, Holston Medical Group, and State of Franklin Health Associates.

(xi) 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 32 - Updated Financial Projections for New Health System

Income Statement - NewCo Baseline	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	**$ 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**

Exhibit 32 - Updated Financial Projections for New Health System

Balance Sheet - NewCo Baseline	Actuals			Forecasted				
$'000s	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**

Exhibit 32 - Updated Financial Projections for New Health System

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**

Exhibit 32 - Updated Financial Projections for New Health System

Income Statement - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	FYE 6/13	FYE 6/14	FYE 6/15	Year 1	Year 2	Year 3	Year 4	Year 5
Net patient service revenue ("NPSR")	**$ 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**

Exhibit 32 - Updated Financial Projections for New Health System

Balance Sheet - NewCo with Preliminary Efficiency Estimates	Actuals			Forecasted				
$'000s	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**

Exhibit 32 - Updated Financial Projections for New Health System

Statement of Cash Flows - NewCo with Preliminary Estimated Efficiencies	Forecasted				
$'000s Scenario	Year 1	Year 2	Year 3	Year 4	Year 5
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**

SUPPLEMENT TO RESPONSES TO QUESTIONS

SUBMITTED MAY 27, 2016

BY

SOUTHWEST VIRGINIA HEALTH AUTHORITY

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: July 25, 2016

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ACCESS

14. What are the current number of licensed healthcare professionals by county and facility in Southwest Virginia employed by the Applicants and what is your projection on what that number will be following the adoption of the Cooperative Agreement?

RESPONSE: **Exhibit 14** to these Responses shows the number of licensed physicians employed by the Applicants, along with their county of location, and reflects the most current information available to the Applicants.[1] The Applicants did not have accurate facility-specific information, and note that facility data is difficult to calculate because physicians may be affiliated with or practice at multiple facilities. The New Health System will employ approximately 3,800 total Virginia residents upon closing. Of these 3,800 Virginia residents, nearly 40% will work in Tennessee.

Regardless of the merger, it is not possible to project the number of employees in any specific region as those numbers vary based on volumes, and the full-time equivalent employee numbers adjust frequently—especially in the clinical environment. The number of employees of the New Health System in the Geographic Service Area will depend on the following factors: patient demand (the number of patients that the New Health System serves in both inpatient and outpatient settings); the population size; and the age mix of the population. Beyond these factors, which affect both Applicants currently, the merged organization will create demand for certain jobs based on the New Health System's commitments in the Application.[2] The future job needs of the New Health System will be affected by the expansion of certain new services based on regional need and the expansion of population health management staffing, such as case managers, health coaches, chronic disease management personnel, nurse navigators, community health workers, mental health and substance abuse professionals, and others to be identified based on service demand in the region's communities.

COMPETITION

47. What is the share of hospital services furnished by any other hospital (not an applicant) in the primary service area and the secondary service area of the proposed New Health System? What is the share of physician and attending care furnished by independent physician practitioners, not employed by either applicant or affiliated systems, in the primary service area and the secondary service area?

RESPONSE: The 75%/90% area data is provided at the Authority's request and is consistent with the Authority's guidance defining these areas based on zip codes. However, the Parties believe that the Geographic Service Area defined in the Application more accurately represents the current competitive service area of the Parties and the expected future competitive service area of the New Health System. As more fully discussed in Response #10, the Geographic Service Area (i) is where the Applicants propose to conduct business as the New Health System and includes the Virginia and Tennessee counties in which the Applicants have locations and

[1] Physician data include physicians and licensed mid-level healthcare professionals such as Physician Assistants and Nurse Practitioners; the Parties have made every effort to provide data and information on these latter licensed health care professionals in responding to this question. See Response #47 for a description of the limitations on calculating county and geographic physician data.

[2] See Application Section 17, pages 129-134.

facilities and serve residents; (ii) contains all locations and providers that will be under the control of the Applicants and subject to any regulation under the Cooperative Agreement in Virginia and the COPA in Tennessee; (iii) includes the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured; (iv) is the source of meaningful outmigration by its residents to Wythe, Hamblen and Cocke Counties for health care services; (v) is a destination for health care of patients residing in Wythe, Hamblen and Cocke Counties; (vi) accurately reflects the little relevance of county or state lines for health care treatment in this region; and (viii) represents a patient population with aligned health care needs.

Hospital Services. The Applicants have calculated the share of inpatient hospital services furnished by other hospitals in the primary (75%) and the secondary (90%) areas of the New Health System, and they are shown on **Exhibits 12A and 12B** to these Responses[3]. The shares of hospital services furnished by other hospitals within the 75% and 90% service areas were calculated by examining the shares of total area discharges.

Physician Services. **Exhibit 47** to these Responses shows counts of independent physicians in the 75% and 90% service areas. The Applicants 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 Virginia Hospital and Healthcare Association and to the Tennessee Hospital Discharge Data System and are available for estimated service area and 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 source.
- 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 47** are provided based on counts of physicians, and allocating physicians to independent groups (and their corresponding locations), which account for a large proportion of physicians in the Geographic Service Area. The Applicants 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.

Since the time the Application was submitted in February to today, a number of Wellmont employed and Mountain States employed and affiliated physicians have been hired, have left employment, and have retired. The information included in **Exhibit 47** reflects the most current information available to the Applicants. Accordingly, to reflect the changes in employment and affiliation that have occurred since February, the Applicants have included in these Responses an updated **Exhibit 14.1 (Section E)** to the original Application for reference (see below). **Application Exhibit 14.1 (Section E)** (as revised in these Responses) includes counts of physicians by specialty for both Wellmont and for Mountain States (employed and affiliated)

[3] Calculations based on data from the Virginia Hospital and Healthcare Association and discharge data from the Tennessee Hospital Discharge Data System.

and for independent physicians. Regardless of how one attempts to calculate data for physician services, the data reveal that there are numerous alternatives in the region for physician services.

REPLACEMENT OF EXHIBIT 14.1 (SECTION E) TO ORIGINAL APPLICATION DATED FEBRUARY 16, 2016

The Applicants submit attached **Application Exhibit 14.1 (Section E)** as a replacement for **Application Exhibit 14.1 (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 Applicants' ongoing effort to calculate physician data as accurately as possible.

LIST OF EXHIBITS

Exhibit Number	Description
14	Applicants' Licensed Physicians
47	Independent Physicians
Replacement Application Exhibit 14.1 (Section E)	E. Physician Services

Exhibit 14. Counts of Employed Physicians by County in Virginia[1]

County	WHS Employed	MSHA Employed	MSHA Affiliated	Independent
VIRGINIA TOTAL	100	104	54	539
BRISTOL CITY	15	0	0	0
BUCHANAN	0	0	0	24
DICKENSON	0	0	4	17
GRAYSON	0	0	0	4
LEE	2	0	0	16
NORTON CITY	37	0	0	0
RUSSELL	8	8	0	33
SCOTT	0	0	0	19
SMYTH	0	3	0	39
TAZEWELL	0	0	0	96
WASHINGTON, VA	23	67	28	130
WISE	12	7	17	86
WYTHE	3	19	5	75
ALL OTHER COUNTIES	240	195	44	1,637
TOTAL	340	299	98	2,176

[1] Physician data include physicians and licensed mid-level healthcare professionals such as Physician Assistants and Nurse Practitioners.

Exhibit 47. Counts of Employed Physicians by System and the 75% and 90% Service Areas

Service Area	WHS Employed	MSHA Employed	MSHA Affiliated	Independent	NewCo %
75% SA Counties	336	280	93	1,805	28.2%
90% SA Counties	337	280	93	1,930	26.9%
Other Counties in GSA	3	19	5	246	9.9%

Notes: ZIP codes were not available for many physicians; we used county approximations of the 75% (PSA) and 90% (SSA) service areas. 90% Service Area excludes Hamblen, Wythe, and Cocke Counties; 75% Service Area additionally excludes Buchanan, Tazewell, and Hancock Counties. Physician data include physicians and licensed mid-level healthcare professionals such as Physician Assistants and Nurse Practitioners.

Replacement Application Exhibit 14.1 (Section E). Physician Status by Specialty/Employment[1]

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%
ORTHOPEDICS	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%

[1] 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. The Specialty categories included in this table may differ slightly from those included in the original Application Exhibit 14.1 (Section E). The information available to the Parties on employed, affiliated and independent physicians in the area utilizes 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. Physician data include physicians and licensed mid-level healthcare professionals such as Physician Assistants and Nurse Practitioners.