

## APPENDIX F

**13. Meetings with Governmental Officials. Attach as Appendix F summaries of all meetings with federal, state, or local authorities regarding any filings or documents referenced in Request #12. Also, include each and every document which memorializes or discusses any and all meetings or other communications with the United States Internal Revenue Service or any other state, federal or local governmental entity in connection with the Transaction.**

Over the course of negotiating and planning this Transaction, the parties have had a significant number of meetings and communications with federal, state, and local authorities:

- Meetings and communications regarding filings and documents referenced in the response to Question 12/Appendix E;
- Meetings and communications with state officials related to passage of Public Chapter 464 of the Acts of 2015.
- Meetings and communications with state and local officials related to the Certificate of Public Advantage application filed with the Tennessee Department of Health and the Tennessee Attorney General's Office;
- Meetings and communications with the Tennessee Attorney General's Office regarding the parties' response to the Public Benefit Hospitals Request for Information Packet; and
- Periodic reports on the status of the Transaction to state and local officials who represent the affected region.

The parties will provide additional information on these communications upon request.

**APPENDIX G**

**15. Letters of Intent. Attach as Appendix G any and all drafts and final versions of any and all letters of intent, confidentiality agreements, or other documents initiating negotiations, contact, or discussions between the Acquirer and the Public Benefit Hospital.**

First drafts, final versions and a comparison document showing negotiated changes to the initial drafts of the non-disclosure agreement and term sheet are included in this Appendix G. Additional interim drafts are available upon request.

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1. Non-disclosure Agreement between Wellmont and Mountain States
  - Executed agreement dated April 2, 2014  
[\*\*\*Following Attachments are Confidential\*\*\*]

[This section left intentionally blank.]

[\*\*\*End of Confidential Attachments\*\*\*]

11. Term Sheet
  - Executed version, April 2, 2015  
[\*\*\*Following Attachments are Confidential\*\*\*]

[This section left intentionally blank.]

[\*\*\*End of Confidential Attachments\*\*\*]



April 2, 2014

Mr. Marvin Eichorn  
Corporate Chief Financial Officer  
Mountain States Health Alliance  
400 North State of Franklin  
Johnson City, Tennessee 37604-6094

Dear Mr. Eichorn:

In order to allow you to evaluate a possible business combination (the "Proposed Business Combination") with Wellmont Health System ("Wellmont"), we will deliver to you, upon your execution and delivery to us of this letter agreement, certain information about the properties and operations of Wellmont. All information about Wellmont furnished by us or our Representatives (as defined below), whether furnished before or after the date hereof, whether oral or written, and regardless of the manner in which it is furnished, is referred to in this letter agreement as "Proprietary Information." Proprietary Information does not include, however, information which (a) is or becomes generally available to the public other than as a result of a disclosure by you or your Representatives, (b) was available to you on a non-confidential basis prior to its disclosure by us or our Representatives or (c) becomes available to you on a non-confidential basis from a person other than us or our Representatives who is not otherwise bound by a confidentiality agreement with us or any Representative of ours, or is otherwise not under an obligation to us or any Representative of ours not to transmit the information to you. As used in this letter agreement, the term "Representative" means, as to any person, such person's affiliates and its and their directors, officers, employees, agents, advisors (including, without limitation, financial advisors, counsel and accountants) and controlling persons. As used in this letter agreement, the term "person" shall be broadly interpreted to include, without limitation, any corporation, company, partnership, other entity or individual.

Except as required by law, unless otherwise agreed to in writing by us, you agree (a) to keep all Proprietary Information confidential and not to disclose or reveal any Proprietary Information to any person other than your Representatives who are actively and directly participating in your evaluation of the Proposed Business Combination or who otherwise need to know the Proprietary Information for the purpose of evaluating the Proposed Business Combination and to cause those persons to observe the terms of this letter agreement, (b) not to use Proprietary Information for any purpose other than in connection with your evaluation of the Proposed Business Combination or the consummation of the Proposed Business Combination in a manner that we have approved and (c) not to disclose to any person (other than those of your Representatives who are actively and directly participating in your evaluation of the Proposed Business Combination or who otherwise need to

Mr. Marvin Eichorn  
Mountain States Health Alliance  
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know for the purpose of evaluating the Proposed Business Combination and, in the case of your Representatives, whom you will cause to observe the terms of this letter agreement) any information about the Proposed Business Combination, or the terms or conditions or any other facts relating thereto, including, without limitation, the fact that discussions are taking place with respect thereto or the status thereof, or the fact that Proprietary Information has been made available to you or your Representatives. You will be responsible for any breach of the terms of this letter agreement by you or your Representatives.

All requests for information from Wellmont shall be coordinated through Kaufman, Hall & Associates, Inc. ("Kaufman Hall"). No employees of Wellmont or other personnel at Wellmont's facilities (including without limitation members of the medical staff of such facilities) shall be contacted by you or any of your Representatives, nor shall you nor any of your Representatives visit Wellmont's facilities, other than in the ordinary course of business, without the prior approval of Kaufman Hall.

In the event that you are requested pursuant to, or required by, applicable law or regulation or by legal process to disclose any Proprietary Information or any other information concerning Wellmont or the Proposed Business Combination, you agree that you will provide us with prompt notice of such request or requirement in order to enable us to seek an appropriate protective order or other remedy, to consult with you with respect to our taking steps to resist or narrow the scope of such request or legal process, or to waive compliance, in whole or in part, with the terms of this letter agreement. In any such event, you will use your reasonable best efforts to ensure that all Proprietary Information and other information that is so disclosed will be accorded confidential treatment.

You acknowledge that none of Wellmont, Kaufman Hall, or our other Representatives and none of the respective officers, directors, employees, agents or controlling persons or such other Representatives makes any express or implied representation or warranty as to the accuracy or completeness of any Proprietary Information, and you agree that none of such persons shall have any liability to you or any of your Representatives relating to or arising from your or their use of any Proprietary Information or for any errors therein or omissions therefrom. You also agree that you are not entitled to rely on the accuracy or completeness of any Proprietary Information and that you shall be entitled to rely solely on such representations and warranties regarding Proprietary Information as may be made to you in any final written business combination agreement relating to the Proposed Business Combination, subject to the terms and conditions of such agreement.

If you determine that you do not wish to proceed with the Proposed Business Combination, you will promptly advise us of that decision. In that case, or in the event that we, in our sole discretion, so request, or the Proposed Business Combination is not consummated by you, you will, upon our request, promptly deliver to Kaufman Hall, or destroy, at your election, all Proprietary Information, including all copies, reproductions, summaries, analyses or extracts thereof or based thereon in your possession or in the possession of any of your Representatives, except that you may retain one (1)

Mr. Marvin Eichorn  
Mountain States Health Alliance  
April 2, 2014  
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copy of all Proprietary Information in your secure legal files for legal retention purposes. If you elect to destroy Proprietary Information, your authorized officer will certify in writing to us that such Proprietary Information (including any Proprietary Information held electronically but excluding backup tapes or other media made pursuant to automated archival processes in the ordinary course of business) has been destroyed. Notwithstanding the return, destruction, or limited retention of Proprietary Information, you and your Representatives will continue to be bound by their obligations of confidentiality and other obligations hereunder.

You agree that until a final written business combination agreement regarding the Proposed Business Combination has been executed by you and us, neither we nor any of our Representatives or you or any of your Representatives are under any legal obligation, and shall have no liability to you, of any nature whatsoever with respect to the Proposed Business Combination by virtue of this letter agreement or otherwise. You also acknowledge and agree that (i) we and our Representatives may conduct the process that may or may not result in the Proposed Business Combination in such manner as we, in our sole discretion, may determine (including, without limitation, negotiating and entering into a final business combination agreement with any third party without notice to you) and (ii) we reserve the right to change (in our sole discretion, at any time and without notice to you) the procedures relating to our and your consideration of the Proposed Business Combination (including, without limitation, terminating all further discussions with you and requesting that you return all Proprietary Information to us).

Without prejudice to the rights and remedies otherwise available to us, you agree we shall be entitled to equitable relief by way of injunction or otherwise if you or any of your Representatives breach or threaten to breach any of the provisions of this letter agreement.

It is further understood and agreed that no failure or delay by us in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder.

For purposes of all communications under this letter agreement, the authorized representatives and addresses of the parties, subject to change upon written notice, are:

If to Wellmont:

Wellmont Health System  
1905 American Way  
Kingsport, TN 37660

Attention: Gary D. Miller  
Senior VP/ General Counsel

If to the Recipient:

Mountain States Health Alliance  
400 North State of Franklin  
Johnson City, Tennessee 37604-6094

Attention: Marvin Eichorn  
Corporate Chief Financial Officer

Mr. Marvin Eichorn  
Mountain States Health Alliance  
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This letter agreement shall be governed by and construed in accordance with the laws of the State of Tennessee without regard to its choice of law provisions.

This letter agreement shall expire on the earlier of (i) the execution of a definitive agreement between you and Wellmont or (ii) two (2) years from the date hereof.

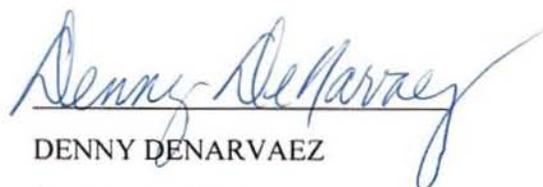
You are not permitted to assign this letter agreement and any assignment by you without our prior written consent shall be null and void. Wellmont may assign its rights and obligations under this letter agreement without your consent.

This letter agreement contains the entire agreement between you and us concerning confidentiality of the Proprietary Information, and no modification of this letter agreement or waiver of the terms and conditions hereof shall be binding upon you or us, unless approved in writing by each of you and us.

Please confirm your agreement with the foregoing by signing and returning to Kaufman Hall, a copy of this letter agreement.

Sincerely,

WELLMONT HEALTH SYSTEM



DENNY DENARVAEZ

*President and CEO*

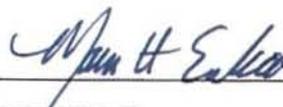
Wellmont Health System

Accepted and Agreed

as of the date first written above:

MOUNTAIN STATES HEALTH ALLIANCE

*Authorizing Signature / Date*



MARVIN EICHORN

*Corporate Chief Financial Officer*

Mountain States Health Alliance





*This term sheet is intended for discussion purposes only and does not constitute and will not give rise to any legally binding obligation on the part of any party to these discussions or any affiliates of any party to these discussions. None of the parties to these discussions or any of their respective affiliates shall be legally bound with respect to the transactions contemplated by this term sheet unless and until such parties have executed and delivered to each other definitive, binding written agreements in respect of such transactions.*

<b>NON-BINDING PROVISIONS</b>	
<b><u>I. Transaction Structure</u></b>	<p>A. Wellmont and Mountain States shall adopt a statement of Shared Vision and Guiding Principles consistent with the statements attached as Exhibit A to this term sheet.</p> <p>B. The form of transaction will be the formation of a new entity which will serve as the parent of Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("Mountain States") (the "Transaction").</p> <p>C. Wellmont and Mountain States will cause a new, not for profit, tax exempt corporation to be incorporated in Tennessee ("Newco"). Newco shall be established as an independent not for profit, Tennessee corporation which shall be governed by a Board of Directors composed of residents from the Tri-Cities area of Tennessee and Virginia as set forth below.</p> <p>D. Wellmont and Mountain States collectively (the "Parties") will amend, modify or revise their respective articles and bylaws to designate Newco as the sole corporate member of each of the Parties.</p>
<b><u>II. Timing and Due Diligence</u></b>	<p>A. The Parties will mutually agree on a time schedule for conducting and completing due diligence and negotiating the Definitive Agreement, it being contemplated that such actions will be completed within one hundred fifty (150) days following signing of this term sheet.</p> <p>B. Subject to the "Protocols on Information Sharing" section below, each of Mountain States and Wellmont shall use reasonable efforts to provide access to the information, employees or contractors requested by the other Party on a timely basis and shall provide to the other Party reasonable access to its facilities upon prior notice.</p> <p>C. Neither Party (nor such Party's representatives) will contact the employees or other personnel of the other Party (including without limitation members of the medical staffs of such Party's hospitals, and no inspection will be conducted, without such Party first coordinating such inspection or contact with, in the case of Wellmont, <u>Gary Miller, Esq.</u> or his designees and in the case of Mountain States, <u>Tim Belisle, Esq.</u> or his designees.</p>
<b><u>III. Governance - Board of Directors</u></b>	<p>A. After execution of this term sheet or similar legal document, Wellmont and Mountain States will, at the appropriate and mutually agreed upon time, jointly engage third party consultants to assist with the selection, development, education and various other tasks related to establishing and integrating the Newco Board, as well as a third party consultant to conduct a culture audit of the two organizations in order to better inform</p>

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the Newco Board on how best to integrate the two organizations from a human relations and cultural standpoint.

- B. Upon execution of this term sheet or similar legal document, Wellmont and Mountain States will each nominate an equal number of their existing board members to become members of the pre-closing Joint Board Task Force. Further, the CEOs of Wellmont and Mountain States will each serve on the Joint Board Task Force. The total number of members of the Joint Board Task Force will not exceed 14. This Joint Board Task Force will oversee the pre-closing activities of the Integration Council. Given the significance of issues to be managed pre-closing, it is highly desirable the individuals who are selected to serve on the Joint Board Task Force also be those who will ultimately serve on the Newco Board.
- C. The initial Newco governing board will be comprised of 14 voting members, as well as two ex-officio voting members and one (1) ex-officio non-voting member. The two ex-officio voting members shall be the Newco Executive Chairman/President and the Newco Chief Executive Officer.
  - 1. The Newco Chief Executive Officer will serve as a voting member of the Newco Board for not longer than two (2) years. At the conclusion of the Chief Executive Officer's two (2) year term, the Chief Executive Officer will rotate off the Newco Board. Upon rotation of the Chief Executive Officer off of the Newco Board, the initial Wellmont designees to the Newco Board (as described in Section D. below) shall appoint a new member to the Newco Board to replace the Chief Executive Officer. The initial term of this new Board member shall be three (3) years, with the opportunity to serve on additional three (3) year term.
  - 2. The one ex-officio non-voting member shall be the then current President of East Tennessee State University.
  - 3. The Board shall include not less than 4 licensed physicians who are members of the medical staff of one or more Newco-affiliated hospitals, with at least two (2) physicians from each legacy system. The total Newco board shall be composed of a maximum of sixteen (16) voting members.
  - 4. Should there be a change in the Executive Chairman/President within the first twenty-four (24) months, for any reason, it is the intent of both Parties to define a process for inclusion in the Definitive Agreement that would maintain the balance of the Newco Board between the legacy systems.
- D. Wellmont and Mountain States will each designate 6 members to serve on the initial board of Newco. Wellmont and Mountain States will jointly select 2 members of the initial Newco board, who will not be incumbent members of either Party's board.
- E. The initial members of the Newco board will be selected with the goals of

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(1) obtaining a broad range of competencies, skills and experience relevant to the governance of a large healthcare system and (2) ensuring broad representation from the region, employer and patient communities served by Newco. Both organizations agree the ultimate goal is for Newco to be governed by a board that is competency-based and utilizing industry best practices.

- F. The initial Newco board appointments will be for staggered terms, with 6 members having a term of two (2) years, four (4) board members with terms of three (3) years, and four (4) board members with terms of four (4) years. The two (2) Board members jointly appointed by the initial Wellmont and Mountain States members shall be in the class with an initial four-year term. The initial board members may serve their initial terms and one additional three-year term. Thereafter, limits on the number of terms of service for board members who succeed the initial board members will be agreed upon and set forth in the Newco bylaws to be adopted at the closing. For the first four years, the staggered terms shall be constructed so that legacy Board members from Wellmont and Mountain States will roll off the Board in equal numbers. If a legacy member resigns or is removed from office during his or her initial term, the person appointed to that position shall come from the same legacy organization and shall serve the unexpired term. Any renewal terms shall be subject to customary board governance policies and procedures.
- G. As and after the initial board terms expire, the Newco board will be self-perpetuating. Newco bylaws will provide that Board members will be subject to term limits as discussed above.
- H. The Newco board will have the ultimate fiduciary duties and governing role for the key business decisions, activities and management of the new health system. The Newco Board shall adopt governance best practices, including periodic performance evaluation. The governance best practices shall be further enumerated in the Newco bylaws.
- I. The Definitive Agreement shall provide for an Executive Chairman (see Section IX *infra*) and a Vice Chairman/Lead Independent Director (to be nominated by Wellmont and affirmed by the non-management members of the Joint Board Task Force and named in the Definitive Agreement) whose responsibilities will be substantially similar to the description attached as Exhibit B to this term sheet. The term of the initial Vice Chairman/Lead Independent Director will be two years after the closing.
- J. The Officer and Executive Committee positions of the Newco Board will be defined in the initial Newco Bylaws to be adopted in accordance with the Definitive Agreement. There will be 4 Board Officer positions to be filled as follows: Executive Chair, Vice Chair, Treasurer, and Secretary. Additionally, there will initially be two at-large members of the Executive Committee.
- K. Upon closing of the Transaction and the constitution of the Newco Board, the existing Wellmont and Mountain States Boards may be delegated certain responsibilities by the Newco Board, such as credentialing,

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	<p>subsidiary and joint-venture oversight, and implementation of Newco Board decisions as required to transition to one governance structure. It is anticipated that the Wellmont Board and Mountain States Board will be dissolved at such time that the Newco Board makes the decision to do so, but not later than 24 months after the closing of the Transaction, with their functions, authority and responsibilities transferred to the Newco Board and its Committees. It is also anticipated that during the transition period between closing and dissolution of each board, the existing Wellmont Board and Mountain States Board will have delegated responsibility for the following:</p> <ol style="list-style-type: none"><li>1. Medical staff credentialing and oversight as those functions currently are outlined in each organization's bylaws;</li><li>2. Official business of any subsidiary corporation subject to Newco Board's final authority as sole Member over such decisions; and</li><li>3. Regulatory oversight such as those requirements contained within the accreditation standards for hospitals and all other subsidiary services.</li></ol>
<p><b>IV. <u>Governance - Board Subcommittees</u></b></p>	<p>A. Board committees will also be established with initial membership of equal representation by and from the Parties.</p> <p>B. Likely committees will include: Executive, Audit; Finance; Legal/Regulatory/Compliance; Quality; Human Resources; Governance; Investments; and Nominating.</p> <p>C. The final committee structure, committee charters, initial membership, and initial chairs of each will be mutually agreed upon and defined in the Definitive Agreement.</p> <p>D. The Executive Chairman/President of Newco will be an ex-officio, non-voting member of the Nominating Committee. The Nominating Committee charter will establish the criteria for selecting future board and committee members.</p>
<p><b>V. <u>Supermajority Items</u></b></p>	<p>A. For a period of time post-Transaction, not to exceed two (2) years, certain board actions will require approval by a supermajority (defined as two-thirds) vote.</p> <p>B. The specific list of actions requiring supermajority approval will be identified in the Definitive Agreement, but will include the following:</p> <ol style="list-style-type: none"><li>1. Amendments to Newco charter and bylaws;</li><li>2. Sale of substantially all of the assets of Newco, or merger of Newco with or into another entity;</li><li>3. Sale or closure of any hospital;</li><li>4. Debt incurrence above an amount to be set forth in the Newco bylaws;</li><li>5. Decision to file bankruptcy or insolvency proceedings or to seek</li></ol>

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	<p>appointment of a receiver for Newco or key members of its group(s) obligated to repay long-term debt; and</p> <p>6. Discontinuing major clinical services, to be defined in the Definitive Agreement, at a Newco affiliated hospital.</p>
<p>VI. <u>Hospital and Affiliate Governance</u></p>	<p>A. Subject to the provisions of any existing joint-venture and other contractual agreements, the governing boards of all hospitals and other affiliates will be appointed by, and serve at the pleasure of, the Newco board. The Newco Board shall have final authority as sole Member of Newco's ownership interest in any hospital, joint-venture or partnership.</p> <p>B. Except as provided below, the existing governing boards of hospitals and affiliates as of the Transaction closing will continue to serve unless replaced by the Newco board.</p> <p>C. To the degree any of the Boards of any subsidiary or wholly owned corporations of Wellmont and Mountain States have membership constituted to include Board members of Wellmont or Mountain States, such board composition shall be amended such that there is equal representation from Wellmont and Mountain States Board members.</p> <p>D. The composition of the boards of the respective physician organizations of Wellmont and Mountain States will be approved by the Newco Board.</p> <p>E. The charters of the Wellmont and Mountain States foundations will require that their respective funds as of the Transaction closing must be used consistent with the intent of the original donors thereof.</p>
<p>VII. <u>Integration Council</u></p>	<p>A. As legally appropriate after the execution of this term sheet or similar legal document, the Parties will establish an Integration Council comprised of ten to twelve (10-12) members. The Integration Council will have responsibility for retaining an independent consultant to undertake a comprehensive analysis of the clinical, operational and financial functions of Wellmont and Mountain States to (1) identify, substantiate and quantify the cost-savings and quality-enhancement opportunities achievable specifically from the Transaction and (2) describe the timeline and integration plan for achieving these opportunities. The Integration Council will engage, on a regular basis, with this consultant for periodic reports on his/her analysis and supply information as needed to further the analysis, and prepare the Parties for integration to ensure the realization of Newco's clinical, operational and financial potential post-Transaction. The objective of the Integration Council is to ensure a system approach that best serves the needs of the community and region based on objective information.</p> <p>B. Integration Council members may include operating executives, finance executives, legal executives and physician executives. Physician, nurse and other clinical and administrative leaders, shall be called upon to provide input and support to the Integration Council. The Integration Council will be composed of an equal number of representatives from Wellmont and Mountain States. There shall be at least four (4) members of the</p>

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	<p>Integration Council who shall be physicians, with two (2) representatives from each of Wellmont and Mountain States. At least one (1) of each health system's physician representatives on the Integration Council shall be a physician in independent practice from each system.</p> <ul style="list-style-type: none"><li>C. Wellmont and Mountain States may jointly engage additional third party consultants to advise the Integration Council, as needed.</li><li>D. After the execution of this term sheet or similar legal document and until the Transaction closing date, the Integration Council will report to the Joint Board Task Force, to be comprised of existing Wellmont and Mountain States Board members, and the CEOs of Wellmont and Mountain States, acting in a transaction committee role.</li><li>E. All of the activities of the Integration Council prior to Transaction close shall be reviewed and advised in advance by legal counsel to ensure compliance with all applicable legal and regulatory restrictions.</li><li>F. The Integration Council shall develop a draft Newco policy outlining the process for consolidating services and facilities, which policy shall include but not be limited to cultural integration, timetables for actions, input from physicians impacted, and notices to staff and community. The draft policy shall be submitted to the Newco board for approval. Post-Transaction, the Integration Council will cease operations and its functions shall be assumed by the Newco management team.</li><li>G. The Parties will mutually agree and define in the Definitive Agreement the ongoing activities, terms of service and scope of the Integration Council within Newco post-Transaction.</li></ul>
<p><b>VIII. <u>Clinical Council</u></b></p>	<ul style="list-style-type: none"><li>A. Promptly after the Transaction closing, Newco commits to the development of a physician-led Clinical Council (composed of appropriate balances of private physicians, group practice physicians and employed physicians) to guide, oversee and assist in implementation of the plan to integrate clinical activities, service lines and business units, and to advise on any appropriate further clinical integrative actions post-implementation that would result in added growth, operational efficiencies and advancements in patient care. Post-closing, the initial Clinical Council will equally represent physicians whose primary practice venue is Wellmont or Mountain States.</li><li>B. The Clinical Council will include Newco management representatives but will be composed primarily of physician representatives. The Clinical Council will report to the Chief Medical Officer of Newco. The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more Newco-affiliated hospitals, will serve on the Quality Committee of the Newco Board, and will provide ongoing reports on the activities of the Clinical Council to the Newco Board through the Quality Committee function of the Board.</li><li>C. Among other duties, it is anticipated the Clinical Council will work on areas, among others, such as establishing a common standard of care,</li></ul>



	common credentialing, consistent multidisciplinary peer review, where appropriate, and quality performance standards
IX. <u>Newco Management</u>	<p>A. The initial management team (“Initial Management Team”) of Newco shall be as follows:</p> <ul style="list-style-type: none"><li>• Executive Chairman/President: Alan Levine<ul style="list-style-type: none"><li>○ The Executive Chairman/President will be the senior officer of the organization. The evaluation of the Executive Chairman/President’s performance will reside with the Newco Board.</li></ul></li><li>• Chief Executive Officer: Bart Hove<ul style="list-style-type: none"><li>○ The Chief Executive officer will report to the Executive Chairman/President.</li></ul></li><li>• Chief Operating Officer: Marvin Eichorn<ul style="list-style-type: none"><li>○ The Chief Operating Officer will report to the Chief Executive Officer.</li></ul></li><li>• Chief Financial Officer: Alice Pope<ul style="list-style-type: none"><li>○ The Chief Financial Officer will report to the Chief Executive Officer.</li></ul></li></ul> <p>The position description for the Executive Chairman/President shall be substantially similar to the position description attached as Exhibit C to this Term Sheet and ensure the position is the most senior officer of Newco. The Joint Board Task Force will develop and approve the Executive Chairman/President’s contract for inclusion as an exhibit to the Definitive Agreement, and to be executed by the Newco Board upon the closing of the Transaction</p> <ul style="list-style-type: none"><li>• Concurrently with the process for development of the Contract with the Executive Chairman/President, the Executive Chairman/President shall, on behalf of the Joint Board Task Force, negotiate an employment agreement with the Chief Executive Officer for ratification by the Joint Board Task Force. This contract will be included as an exhibit to the Definitive Agreement, and will be executed by the Executive Chairman/President and Chief Executive Officer upon the closing of the Transaction. The position description for the Chief Executive Officer shall be substantially similar to the position description attached as Exhibit D to this Term Sheet.</li><li>• The Chief Executive Officer, in consultation with the Executive Chairman/President, will then develop job descriptions for the remaining Initial Management Team members for inclusion as an exhibit to the Definitive Agreement.</li></ul> <p>B. The Executive Chairman/President and the Chief Executive Officer of</p>

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	<p>Newco will begin the process of assembling the Newco management team (comprised of the direct reports to the Executive Chairman/President and the Chief Executive Officer other than the Initial Management Team), which shall be presented to the Newco Board for approval after the closing. It is anticipated that the Newco management team will be composed of representatives from each Party and will not be composed of the management team from a single Party.</p> <p>C. Upon signing of this term sheet or similar legal document, Wellmont and Mountain States will identify to each other those senior executives with whom each has executed, or will execute, retention and severance agreements.</p> <p>D. It is in the best interest of Newco that the corporate headquarters are easily accessible and conveniently located. Within 2 years of closing, the Newco Board will direct that the Newco Senior Management Team evaluate the most suitable, cost-effective and appropriate location of the corporate headquarters and to make a recommendation to the Board for consideration and approval. The Newco corporate headquarters shall not be located on the campus of any Newco affiliated hospital.</p>
<p><b>X. Employees</b></p>	<p>A. Newco and affiliates will continue employment of (or, as appropriate, extend offers of employment to) all active employees of the Parties upon substantially similar terms and conditions with respect to base salaries and wages, job duties, titles and responsibilities that are currently provided to such employees immediately prior to close, except that certain positions which are identified as synergies may be eliminated. Normal employment practices, including terminations and reductions in force, will be unaffected.</p> <p>B. Newco will honor prior service credit under each Parties' employee plans for purposes of eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will waive any eligibility requirement or pre-existing condition limitation for persons covered under each Parties' employee benefit plans. Newco will provide all employees credit for accrued vacation.</p> <p>C. Newco will work as quickly as practicable after closing to address any required actions with respect to differences in salary/ pay rates and employee benefit structures with a goal of creating consistency throughout the merged health system wherever feasible.</p>
<p><b>XI. <u>Medical Staff</u></b></p>	<p>A. Newco is committed to a pluralistic, physician-led medical staff model that embraces the strengths of private practice, group practice and employed physicians.</p> <p>B. The medical staff members in good standing immediately prior to Transaction closing will maintain their medical staff privileges at the Parties' facilities where such privileges are maintained, subject to the medical staff</p>

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	<p>bylaws then in effect.</p> <p>C. Subject to completion of due diligence, Newco will continue all existing contracts with physicians, including employment agreements, at least until the initial expiration of such contracts.</p> <p>D. All medical staff bylaws of each legacy system will remain in effect until such time as Newco and each respective medical staff develop and approve a new or modified set of medical staff bylaws, should new or modified medical staff bylaws be deemed necessary.</p>
<p><b>XII. <u>Existing Affiliations</u></b></p>	<p>A. Newco will initially maintain the Wellmont and Mountain States joint ventures, affiliations and other outsourced contracts/relationships existing at close.</p> <p>B. Opportunities to optimize such structures will continue to be evaluated by the Newco board and the Integration Council post-Transaction.</p> <p>C. Prior to closing the Transaction any potential conflicts arising under such arrangements that are caused by the Transaction shall, subject to prior advice of counsel, be identified and reviewed by the Integration Council and the Joint Board Task Force. Recommendations by the Integration Council for post-closing actions by Management or Newco Board will be reported to the Board and Counsel.</p>
<p><b>XIII. <u>Information Technology</u></b></p>	<p>A. The Definitive Agreement will provide that all Newco hospitals will fully integrate into the EPIC information system currently used by Wellmont.</p>
<p><b>XIV. <u>Insurance Platforms</u></b></p>	<p>A. As soon as practicable after closing, Newco will review the structure of the existing insurance platforms of Wellmont and Mountain States and work to spread risk, reduce costs and realize efficiencies that result from the Transaction</p>
<p><b>XV. <u>Philanthropic Gifts</u></b></p>	<p>A. Newco will honor the intent of all gifts, bequests, grants and donations provided to either Mountain States or Wellmont by a donor to be used for charitable purposes by a tax-exempt organization.</p>
<p><b>XVI. <u>Community Benefit</u></b></p>	<p>A. Newco commits to operate in accordance with the “community benefit standards” as they apply to 501c(3) hospital non-profit corporations, including, without limitation, the (i) acceptance of all Medicare and Medicaid patients, (ii) acceptance of all emergency patients without regard to ability to pay, (iii) maintenance of an open medical staff, (iv) provision of public health programs of educational benefit to the community, and (v) general promotion of public health, wellness, and welfare to the community through the provision of health care at a reasonable cost.</p> <p>B. The Definitive Agreement will commit Newco to maintaining the Parties’ existing or equivalent community benefit and education programs and services at close.</p> <p>C. In the context of supporting the Certificate of Public Advantage, Newco will conduct, in partnership with East Tennessee State University and other Academic partners, as appropriate, a detailed public health needs</p>

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	<p>assessment in order to identify and prioritize measurable health needs and initiatives. Such initiatives may include, but not be limited to:</p> <ul style="list-style-type: none"><li>• 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;</li><li>• Improvement of behavioral health services, mental health, addiction recovery, and services for people with developmental disabilities;</li><li>• Enhancement of programs to reduce drug abuse in the region, specifically among women in child-bearing years;</li><li>• Establishment of programs to improve health literacy;</li><li>• Development of programs to improve child wellness – physical and emotional;</li><li>• Growth of medical research programs; and</li><li>• 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.</li></ul> <p>D. Newco will abide by policies and provisions of charity care that are no less generous than the policies of the Parties at the time of the Transaction closing, subject to changes in law, policy or regulation as applicable.</p>
<p>XVII. <u>Naming/ Branding</u></p>	<p>A. The Parties will work to mutually agree to the renaming and rebranding of Newco. Upon signing of this term sheet, Wellmont and Mountain States will mutually agree upon and jointly retain a firm to advise and assist them with the rebranding strategy. The rebranding strategy will have goals of establishing a single identity for the merged system that communicates its mission and clearly informs all members of the regional community of the new name, logo(s), and the mission of the merged system.</p>
<p>XVIII. <u>Approvals; Termination</u></p>	<p>A. The execution and delivery of the Definitive Agreement are conditioned on the receipt of all necessary consents and approvals of the appropriate governing boards of Mountain States and Wellmont. Furthermore, it is anticipated that the Definitive Agreement will provide that the consummation of the Transaction will be conditioned upon:</p> <ol style="list-style-type: none"><li>1. The receipt of all material consents of third parties, if any, necessary under material agreements of the Parties for consummation of the Transaction contemplated under the Definitive Agreement;</li><li>2. The filing of all notices and the receipt of all approvals and consents, as required from governmental authorities (including, if applicable, the Attorneys General of the States of Tennessee and Virginia);</li><li>3. The termination of any waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; and</li></ol>

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	<p>4. The satisfaction of such other conditions as are mutually acceptable to the Parties or are legally required.</p> <p>B. It is the intent of both Parties, upon execution of the Definitive Agreement, that both Parties will take all reasonable steps necessary to close the Transaction. Notwithstanding the foregoing, both Parties recognize there may be circumstances of federal and/or state government action or inaction, or extraordinary external factors, that may give rise to the conclusion that the Transaction may be imperiled or it is no longer reasonable to pursue closing of the Transaction. Consequently, the Definitive Agreement shall articulate circumstances upon which either Party may unilaterally terminate the Transaction.</p>
<p><b>XIX. <u>COPA</u></b></p>	<p>A. Without limiting the approvals described above, simultaneously with the negotiation of the Definitive Agreement, the Parties will negotiate a "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993 (the "Act").</p> <p>B. Following execution of the Definitive Agreement, the Parties will apply to the Tennessee Department of Health to obtain, and follow the procedures under the Act for obtaining, a certificate of public advantage (the "Tennessee COPA") to govern the cooperative agreement as provided in the Act.</p> <p>C. At the appropriate time, the Parties shall apply to the Virginia Attorney General, or other appropriate state agency or entity, for a consent order or other appropriate state approvals regarding Newco Virginia operations on substantially the same terms as the Tennessee COPA (the "Virginia Consent Order").</p> <p>D. Subject to the provisions articulated in Section XVIII, Paragraph B above, each Party shall use good faith efforts to obtain the Tennessee COPA and other regulatory approvals necessary to closing of the Transaction. The Definitive Agreement will provide that receipt of the Tennessee COPA and the Virginia Consent Order, or comparable approval, on terms satisfactory to the respective Wellmont and Mountain States Boards, in their reasonable discretion, is a condition to the Parties' respective obligations to complete the Transaction.</p>
<p><b>BINDING PROVISIONS</b></p>	
<p><b>XX. <u>Confidentiality and Disclosure</u></b></p>	<p>A. The Parties have previously entered into a confidentiality agreement dated April 2, 2014 (the "Confidentiality Agreement"). In addition to the provisions contained in that agreement, except as and to the extent required by law, without the prior written consent of the other Party, neither Mountain States nor Wellmont shall, and each shall direct its representatives not to, directly or indirectly, make any public comments, statement or communication with respect to, or otherwise disclose or permit the disclosure of the existence of discussions regarding a possible Transaction or any of the terms, conditions or aspects of the Transaction proposed in this term sheet except in the manner provided by the</p>

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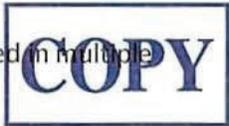
	<p>Confidentiality Agreement. The timing, content and context of any announcements, press releases, public statements, or reports and related matters incident to the matters referenced in this term sheet, or its existence, will be determined in advance by the mutual written consent of the Parties. Further, the Parties will advise each other of communications to their employees and medical staff relating to the Transaction prior to the communication of the same.</p>
<p>XXI. <u>Protocols on Information Sharing</u></p>	<p>A. The Parties recognize that disclosure of certain information may raise unique legal concerns due to the proximity of the Parties' operations and facilities ("Competitive Sensitive Information"). Such Competitive Sensitive Information may include, but is not limited to, information about prices, pricing formulas, costs, rates of provider compensation, strategy or intentions regarding contracting with any provider or purchaser, fee schedules, managed care contracts, premium rates, compensation or benefits information relating to employees, recruitment of medical professionals or others, future expansion plans involving clinical services or pertaining to physicians, and any non-public marketing or strategic planning documents or other competitively sensitive documents relating to a party's future plans. The Parties will only disclose Competitive Sensitive Information in accordance with law as agreed to in advance by the Parties' and their respective legal counsel and to that end, the Parties may enter into one or more protective agreements or develop other arrangements to address the review of such Competitive Sensitive Information to ensure compliance with applicable law.</p>
<p>XXII. <u>Transaction Expenses; Exclusive Negotiations</u></p>	<p>In view of the substantial time and expense involved in obtaining required regulatory approvals, due to the innovative nature of the Transaction:</p> <p>A. With respect to the expenses of the Tennessee COPA (including experts and the Wellmont counsel fees), the Virginia Consent Order and other expenses arising out of this term sheet and the Transaction (collectively referred to as "Expenses"), whether or not the Transaction or any part thereof shall close, Mountain States shall bear 70% of the Expenses, while Wellmont shall bear 30% of the Expenses.</p> <p>B. In consideration of the Parties' significant investment of time and expense in connection with the transactions contemplated by this term sheet, from the date of execution of this term sheet or similar legal document until written termination of negotiations are received by the other Party, neither Party may, without the written approval of the other Party, make or solicit offers for, or hold discussions or negotiations or enter into any agreement with respect to, (a) the sale, lease or management of any of its hospitals or any material portion of its assets or any ownership interest in any entity owning any of its hospitals or any material portion of its assets, (b) any reorganization, merger, consolidation, management agreement, member substitution or joint venture involving any of its hospitals or any material portion of its assets, or (c) any other transaction in which a person or group other than the other Party would acquire the right, directly or indirectly, to</p>

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	control the governing board of, direct the operations of, establish governing or operating policies for, and/or own, lease or otherwise acquire the right to use or control, any of such Party's hospitals or any material portion of its assets (the "Exclusive Negotiations Covenant").
<b>XXIII. <u>Nature of Term Sheet</u></b>	<p>A. The Parties agree that, except for Sections XX-XXIV hereof, this Term Sheet is not intended to be a binding agreement and shall not give rise to any obligations between the Parties.</p> <p>B. Further, due to the complexity of the proposed transaction, it is the expressed intention of the parties that, except for the provisions of Sections XX-XXIV, no binding contractual agreement shall exist between them unless and until Mountain States and Wellmont (and any other necessary parties) shall have executed and delivered a Definitive Agreement, which shall contain the provisions outlined above and the representations, warranties, and other terms and conditions customary in this type of transaction, all of which must be acceptable to all parties in their sole discretion (including, without limitation, contingencies for all necessary regulatory approvals). Any Party may for whatever reason terminate this term sheet and further negotiations by written notice to the other Party. In such event, there shall be no liability between any of the Parties as a result of the execution of this term sheet, any acts or omissions of the parties or their representatives in connection with the proposed transaction, any action taken in reliance on this term sheet, or such termination, except as set forth in Sections XX-XXIV hereof. Notwithstanding the foregoing, termination by either party of this term sheet shall not terminate or otherwise affect the obligations the parties may have to each other pursuant to the Confidentiality Agreement, and pursuant to any separate agreement entered into with respect to Competitive Sensitive Information.</p> <p>C. Prior to execution, this term sheet shall be approved by the Board of Directors of both Wellmont and Mountain States.</p>
<b>XXIV. <u>Governing Law</u></b>	<p>A. The Transaction definitive documents shall be governed by and construed in accordance with the laws of the State of Tennessee without reference to principles of conflicts of law. Wellmont counsel shall prepare the initial drafts of definitive documents.</p>

*(signatures on the following page)*

IN WITNESS WHEREOF, the parties hereto have caused this term sheet to be executed in multiple originals by their duly authorized officers, all as of the date first above written.



**MOUNTAIN STATES HEALTH ALLIANCE**

By: Barbara Allen  
Barbara Allen  
Chair

By: Alan Levine  
Alan Levine  
President and CEO

**WELLMONT HEALTH SYSTEM**

By: Roger Leonard  
Roger Leonard  
Chairman

By: Bart Hove  
Bart Hove  
President and CEO

## Exhibit A

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### Shared Vision and Guiding Principles

#### A Shared Vision for Regional Healthcare

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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

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Beyond a shared vision to develop one of the best health systems in the nation, the new not for profit health system created by the merger of Wellmont Health System and Mountain States Health Alliance will be guided by the following principles and will develop strategic plans to deliver on them.

#### **Mission, Vision, and Strategy**

- Exhibit common values and a compelling vision for healthcare delivery in the region
- Achieve cultural integration across key stakeholder groups and embody a culture of collaboration
- Demonstrate commitment to the Triple Aim of improving the patient experience through enhanced quality and satisfaction, improving the health of populations and reducing the per capita cost of healthcare

#### **Patients**

- Demonstrate a commitment to first class patient experiences and broad community support for programs and services
- Improve and advance the overall health status of patients and communities served, including both healthcare and wellness services, to improve their ability to stay well
- Commit to serving all people in each community—including those with and without the ability to pay
- Develop regional community health needs assessments and implementation plans and update these annually to ensure healthcare gaps and disparities are addressed
- Keep the best interest of patients at the center of everything we do, delivering exceptional value and high quality outcomes

- Facilitate patient access to their preferred physicians
- Create the best practice environment for the physicians who care for our patients
- Maintain and further develop highly specialized medical services



### Physicians

- Support and strengthen our valued community of independent physicians as well as currently employed physicians for the benefit of high-quality patient outcomes
- Create an environment and culture that is attractive to highly qualified physicians and that places equal value on the roles of both independent and employed physicians
- Ensure all physicians have the resources needed to access clinical information and collaborate in the best interest of patients
- Broaden expertise and resources to enhance local medical staff leadership and professional development
- Commit to physician leadership at all levels of system and local administration

### Employees

- Maintain or improve compensation and benefits for employees to levels that are competitive in comparable markets throughout the Southeastern United States and maintain the tenure of employees for eligibility and other purposes
- Create industry leading educational and professional development programs, including continuing education and clinical education
- Create an employment environment that will attract and retain highly qualified clinical and administrative talent in service to our communities

### Clinical Programs, Service, and Quality

- Develop cohesive resources to effectively coordinate the provision of services across the system and ensure seamless access to high quality, cost-effective healthcare services
- Seek to improve primary care access and develop NCQA, level 3 patient-centered medical homes
- Effectively manage rural facilities and align tertiary resources to ensure timely access to appropriate care
- Expand clinical trial programs in heart, cancer, and other areas
- Design a seamless regional care continuum across a full spectrum, including pre and post acute care

### Management & Operations

- Seek opportunities to leverage economies of scale for operational efficiency in corporate management and back office functions
- Enhance clinical support functions that will advance service excellence and quality outcomes
- Leverage any unique capabilities, assets, and programs to maximize effectiveness and efficiency
- Develop proficiency in implementation and management processes and protocols to redesign care, reduce variation, and systematically improve outcomes while lowering cost

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### Investment and Innovation

- Endeavor to remain on the forefront of future developments in healthcare technology
- Develop effective purchasing and financing systems to improve overall cost of capital
- Achieve and maintain an improved approach to overall financial management, resulting in improved finances and bond ratings
- Build a comprehensive Epic platform to support clinical integration, population health management, and connectivity
- Achieve sufficient financial security to ensure commitment of capital and investment in new services, technology, and facilities.

### Population Health Management

- Focus on the purposeful development of a care management/population health model
- Support advancement of population health management locally through quality incentive and risk-bearing payment arrangements, among other appropriate mechanisms
- Develop necessary informatics and analytic systems to support partnerships with payers and employers in new compensation and insurance models.

### Governance

- Instill industry leading governance structures and practices that effectively represent the communities we serve and showcase physician leadership
- Ensure the system possesses the resources, talent, and technology needed to thrive both in the current and the emerging healthcare industry

Exhibit B

**COPY**

Description of the Vice Chair/Lead Independent Director Position

**Charter of the Vice Chair/Lead Independent Director**

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The Vice Chair/Lead Independent Director coordinates the activities of the other non-management Directors, and performs such other duties and responsibilities as the Board of Directors may determine.

The specific responsibilities of the Vice Chair/Lead Independent Director are as follows:

**Presides at Executive Sessions**

- Presides at all meetings of the Board at which the Executive Chairman/President is not present, including executive sessions of the independent Directors.

**Calls Meetings of Independent Directors**

- Has the authority to call meetings of the independent Directors.

**Conducts Evaluation of Executive Chairman/President**

- Ensures independent Director evaluation of the Executive Chairman/President by the Board, including an annual evaluation of his or her performance and compensation.

**Functions as Liaison with the Executive Chairman/President**

- Serves as liaison between the independent Directors and the Executive Chairman/President.

**Approves appropriate provision of information to the Board such as board meeting agendas and schedules**

- Approves meeting information sent to the Board relating to agendas and actions items, including the quality, quantity and timeliness of such information.
- Setting the Board's approval of the number and frequency of Board meetings, and approves meeting schedules to assure that there is sufficient time for discussion of all agenda items.

**Authorizes Retention of Outside Advisors and Consultants**

- Authorizes the retention of outside advisors and consultants who report directly to the Board of Directors on board-wide issues upon approval of the Governance Committee.

**Constituent Communication**

- If requested by constituent groups, ensures that he/she is available, when appropriate, for consultation and direct communication.

## Exhibit C

**COPY**

### Description of the Executive Chairman/President Position

#### Executive Chairman/President

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##### **Leadership**

- Leadership of the board; ensuring the board's effectiveness and engagement in all aspects of its role and, in conjunction with the Vice Chair, setting of its agenda.
- Directing activities which serve to promote the mission.
- Consistent with the shared vision statement, setting the direction for the organization by shaping the vision, setting the strategy, and leading critical negotiations with potential partners.
- Shaping a positive culture: setting the standards, modeling Newco's values, to include a focus on 'system-ness' and value-based performance, research and academics, and innovation.
- In conjunction with the Chief Executive Officer: building leadership capability of the management team; selecting, developing and motivating key leaders and high potential talent to ensure future leadership is capable of meeting current and future organizational needs and is held accountable for system-wide performance.
- Promoting the highest standards of corporate governance.

##### **Meeting**

- Chairing board meetings.
- In conjunction with the Vice Chair, ensuring the board's effectiveness in all aspects of its role, including regularity and frequency of meetings.
- In conjunction with the Vice Chair, setting the board agenda, taking into account the issues and concerns of all board members. The agenda should be forward looking, concentrating on strategic matters.
- Ensuring that the directors receive accurate, complete, timely and clear information, and are advised of all likely future developments and trends, to enable the board to take sound decision and promote the success of the company.

##### **Directors**

- Facilitating the effective contribution of directors and encouraging active engagement by all members of the board.
- Ensuring constructive relations among the directors and between the directors and management.
- Building and maintaining an effective competency based and complementary board, and with the Nomination Committee, initiating change and planning succession in board appointments subject to the bylaws and board approval.

##### **Induction, Development and Performance Evaluation**

- Ensuring new directors are oriented, and provided adequate opportunity to on-board.
- Ensuring that the development needs of directors are identified and met. The directors should be able to continually update their skills, knowledge, and familiarity with the company.
- In conjunction with the Vice Chair, identifying the development needs of the board as a whole to enhance its overall effectiveness as a team and to ensure it receives board education consistent with industry standards for a system of the size and scope of Newco.

- Ensuring the performance of the board, its committees and individual directors is evaluated periodically through the Board Governance Committee, and acting on the results of such evaluation.

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#### **Relations with Stakeholders**

- Ensuring effective communication with all stakeholders, financial institutions, the public and government/regulatory agencies. Serve as the Chief Spokesperson for the Organization with appropriate delegation of authority to the CEO on operational matters.
- Representing Newco to Federal, State and local governing bodies and, either in person or through a designee, serve as Chief Spokesperson and advocate for the interests of Newco and on healthcare issues in general.
- Maintaining and promoting Newco's public image and reputation.

#### **Direct Reports**

The direct reports to the Executive Chairman/President include:

- Chief Executive Officer
- Compliance and Audit (dual reporting responsibility to the Executive Chairman/President and also to Chair of Audit Committee)
- General Counsel (dual reporting to the Executive Chairman/President and to the board.)
- Corporate Communications
- System Development/Philanthropy
- Strategic Planning

#### **Other Responsibilities**

The Executive Chairman/President shall:

- Uphold the highest standards of integrity.
- Ensuring effective implementation of board decisions.
- Ensuring the long-term sustainability of the business through coordination with Newco Board and Management Team.

The Executive Chairman/President is accountable to, and reports to the Newco Board.

The Executive Chairman/President is also responsible for the following:

- Enhancement of external affiliations and relationships.
- Implementing and oversight of compliance with Certificate of Public Advantage or other regulatory agreements.
- Regular review of the operational performance of the company.
- Responsible to the Newco Board for ensuring the provision of the highest quality of patient care and customer service in all Newco facilities and business units.
- Responsible for management of the organization's debt.
- Aligning the organization: continuing to drive the integration of Newco to create a cohesive, responsive organization by eliminating redundancies, capitalizing on economies of scale, and fostering a system mentality.

Exhibit D



Description of the Chief Executive Officer Position

Chief Executive Officer

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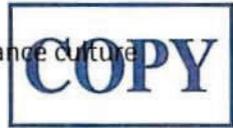
**Leadership**

- The Chief Executive Officer of Newco reports to the Executive Chairman/President and is the senior executive in charge of all business operations of the Newco organization. This executive position requires a combination of operational excellence and system administrative skills and must be attentive to enhanced financial performance in a physician-empowered culture. It is expected that the CEO is adroit in physician relations, physician recruitment and retention.
- This position requires visionary leadership and plays a vital role in creating, implementing and executing the strategy in conjunction with the Executive Chairman/President. Of paramount importance, this position requires the incumbent to establish credibility with employees, physicians, payors, providers and community leaders. The CEO is expected to raise the health system's visibility and reputation in the communities it serves in conjunction with the Executive Chairman/President.
- The CEO position serves as the principal operational leader for the organization and is responsible for driving forward Newco's vision to be the best healthcare delivery system in the region in conjunction with the Executive Chairman/President. This position is the champion for Newco's continued emphasis on "systemness" across the care delivery continuum, to achieve not only its quality and safety goals, but also to increase operational efficiency and provide a consistent point of service contact for its patients.

**Major Responsibilities**

- Possess a professional and personal adherence to the values, mission and philosophy of the Newco organization.
- Expand on the legacy of the quality and safety of patient care services across the system.
- Working closely with the Executive Chairman/President to lead the ongoing review of the current strategic plan and development of future strategic plans; ensure the plan supports the organization's goal of clinical excellence, while at the same time considers the appropriate business model for the medical staff and strategic service opportunities for growth and addresses revenue generation to sustain ongoing growth. Realize the goal of an integrated health system that leverages the advantages of a multi-state and multimarket health.

- In conjunction with the Executive Chairman/President, build a high performance culture characterized by decisiveness, accountability and compassion.



**Direct Reports**

- Chief Operating Officer
- Chief Financial Officer

And the following subject to development of a final organizational chart.

- Chief Medical Officer
- Vice President of Human Resources
- President of Physician Organization

**APPENDIX H**

**16. Contracts or Purchase Agreements. Attach as Appendix H any and all drafts and final versions of asset purchase agreements, contracts or agreements to purchase assets from the Public Benefit Hospital by the Acquirer. Your response must also include any attachments, amendments, schedules, or appendices to such agreements.**

First drafts, final versions and a comparison document showing negotiated changes to the initial drafts are included in this Appendix H. Additional interim drafts are available upon request.

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1. Master Affiliation Agreement
  - Executed version, dated February 15, 2016 (Note: Exhibit C-3, Amended Parent Company Articles, was not drafted at the time the Master Affiliation Agreement was entered into and remains undrafted at the date of this application. Accordingly, that document has not been included in this response.)
  - Exhibit C-1, Interim Parent Company Articles and Interim Parent Company Bylaws (included in response to Question 7/Appendix B)
  - Exhibit C-2, Amended Parent Company Bylaws (included in response to Question 7/Appendix B)

**\*\*\*Following Attachments are Confidential\*\*\***

[This section left intentionally blank.]

**\*\*\*End of Confidential Attachments\*\*\***

4. First Amendment to the Master Affiliation Agreement

- Executed version, dated September 8, 2016

**\*\*\*Following Attachments are Confidential\*\*\***

[This section left intentionally blank.]

**\*\*\*End of Confidential Attachments\*\*\***

EXECUTION COPY

**Master Affiliation Agreement  
and  
Plan of Integration**

**By and Between**

**Wellmont Health System  
and  
Mountain States Health Alliance**

**Dated as of February 15, 2016**

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THIS MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "Agreement") is dated as of February 15, 2016, by and between Wellmont Health System, a Tennessee nonprofit public benefit corporation with a principal place of business in Kingsport, Tennessee ("Wellmont") and Mountain States Health Alliance, a Tennessee nonprofit public benefit corporation with a principal place of business in Johnson City, Tennessee ("MSHA"). Wellmont and MSHA are each a "Party" and collectively the "Parties."

WHEREAS, 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

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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-1. 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 seventeen (17). 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

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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

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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.

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(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.

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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, the Virginia Limited Liability Company Act, or the Companies Law of the Cayman Islands, 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.

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(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

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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

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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

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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. Except as set forth in the Wellmont Counsel Memorandum, 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

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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

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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. With respect to all real property reflected on the respective balance sheets of Wellmont and the Wellmont Subsidiaries (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.

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(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

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(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

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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

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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 policies 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

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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

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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

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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

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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

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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.

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(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

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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. Except as set forth in the MSHA Counsel Memorandum, 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,

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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. With respect to all real property reflected on the respective balance sheets of MSHA and the MSHA Subsidiaries (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

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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

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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

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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

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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:

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(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

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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 policies 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

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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

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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 its Counsel Memorandum 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;

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(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.

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(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

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(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.

Section 5.07 Resolution of Open Diligence Items. Each Party has identified for the other Party specific items (the “Open Diligence Items”) which arose from the identifying Party’s diligence of the other Party, about which the identifying Party has requested the other Party to provide additional information. Each Party shall provide to the identifying Party, as soon as practicable, but in any event within sixty (60) days after the signing of this Agreement, such additional information concerning the Open Diligence Items as the identifying Party may reasonably request. Thereafter, each Party will use good faith efforts to resolve the questions, comments and concerns raised by the identifying Party with respect to the Open Diligence Items, including without limitation, providing additional information concerning the Open Diligence Items as the identifying Party may reasonably request.

### **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

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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 Matters.

(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 issued written notice of his decision to take no action with respect to the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-201, et seq.

(c) The Attorney General of Virginia shall not have issued any correspondence or communication to the parties indicating that the Attorney General will take action with respect to any notice filing made 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 the foregoing regulatory approvals shall be satisfactory in form and substance to the Board of Directors of MSHA.

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### Section 6.06 Absence of Material Adverse Change.

(a) 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.

(b) Neither (i) the Open Diligence Items identified by MSHA which have not been resolved to the reasonable satisfaction of MSHA, nor (ii) any litigation pending against Wellmont, 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.

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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 issued written notice of his decision to take no action with respect to the Affiliation pursuant to the Tennessee Public Benefit Hospital Sales and Conveyance Act of 2006, Tennessee Code §§ 48-68-201, et seq.

(c) The Attorney General of Virginia shall not have issued any correspondence or communication to the parties indicating that the Attorney General will take action with respect to any notice filing made 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 the foregoing regulatory approvals shall be satisfactory in form and substance to the Board of Directors of Wellmont.

### Section 7.06 Absence of Material Adverse Change.

(a) 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.

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(b) Neither (i) the Open Diligence Items identified by Wellmont which have not been resolved to the reasonable satisfaction of Wellmont, nor (ii) any litigation pending against MSHA, would reasonably be expected to have a Material Adverse Effect with respect to MSHA.

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

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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 the Initial Directors changes, then the individuals on the Joint Board Task Force will be modified to conform to the expected identity of the Initial Directors.

Section 9.02 Integration Council. The Parties have established an Integration Council, comprised of twelve (12) members listed on Exhibit F, as a nonexclusive means to prepare the parties for integration, and, among other things, to retain independent consultant (the "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. 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. Establishment of the Integration Council is not intended to be the sole means to prepare for post-Closing integration of the Parties to establish the Parent Company health system. The directors, officers and management teams of each party may take such other planning steps as they determine to be necessary or appropriate to prepare for the post-Closing integration. 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

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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.

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### 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

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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.

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(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 February 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 15, 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 15, 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 March 15, 2016, within fifteen (15) days after the end of each calendar quarter thereafter 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 quarter, 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.

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(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

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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.

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### 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]*

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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

  
\_\_\_\_\_  
Bart Hove  
President and CEO

**MOUNTAIN STATES HEALTH ALLIANCE**

By:   
\_\_\_\_\_  
Barbara Allen  
Chairman of the Board of Directors

  
\_\_\_\_\_  
Alan Levine  
Chief Executive Officer

**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)

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- 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%)

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- WPS Providers, Inc. (100%)

**EXHIBIT B**

**Shared Vision and Guiding Principles**

A Shared Vision for Regional Healthcare

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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.

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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

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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

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### **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**

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- 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

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**EXHIBIT C-1**

**Interim Parent Company Articles and Interim Parent Company Bylaws**

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**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

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**EXHIBIT C-3**

**Amended Parent Company Articles**

EXECUTION COPY

**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**

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- 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.

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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.

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- 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).

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- 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

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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)(ii).
- 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).

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- 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.

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**First Amendment to  
Master Affiliation Agreement  
and  
Plan of Integration**

**By and Between**

**Wellmont Health System  
and  
Mountain States Health Alliance**

**Dated as of September 8, 2016**

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## EXECUTION COPY

THIS FIRST AMENDMENT TO MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "First Amendment") is dated as of September 8, 2016, by and between Wellmont Health System, a Tennessee nonprofit public benefit corporation with a principal place of business in Kingsport, Tennessee ("Wellmont") and Mountain States Health Alliance, a Tennessee nonprofit public benefit corporation with a principal place of business in Johnson City, Tennessee ("MSHA"). Wellmont and MSHA are each a "Party" and collectively the "Parties."

WHEREAS, the Parties have entered into the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016 (the "Agreement"); and

WHEREAS, the Parties have agreed to amend certain provisions of the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the representations, warranties, premises and the mutual covenants and agreements hereinafter contained, each of the parties hereto, intending to be legally bound, hereby agree as follows:

### **Article I. Amendments.**

Section 1.01 Exhibits C-2 and F. Exhibit C-2 (Interim Officers) and Exhibit F (Integration Council) are deleted in their entirety and replaced with the correspondingly labeled Exhibits attached hereto.

Section 1.02 Cooperative Agreement. Section 5.06(a) of the Agreement is amended to read in its entirety as follows:

(a) The Parties deem this Agreement to be their "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993, as amended (the "Tennessee COPA Act") and § 15.2-5369 of the Code of Virginia (the "Virginia COPA Act" and together with Tennessee COPA Act, the "COPA Acts"). Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties hereby agree upon and incorporate the terms contained in Exhibit H as part of this "cooperative agreement."

Section 1.03 Exhibit H. The Agreement is amended by adding a new Exhibit H as labeled and attached hereto.

Section 1.04 Amendment, No Further Modification. The Parties agree that this First Amendment is an effective and binding amendment of the Agreement pursuant to Section 10.07 of the Agreement. Except as otherwise expressly stated in this First Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect, without amendment or modification.

Section 1.05 Capitalized Terms. Capitalized terms used but not otherwise defined herein shall have the same meaning ascribed to such terms in the Agreement.

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Section 1.06 Execution in Counterparts. This First Amendment may be executed in more than one counterpart, each of which shall be deemed to be an original, but all of which shall be deemed to constitute one instrument. It shall not be necessary for all parties to have signed the same counterpart provided that all parties have signed at least one counterpart.

*[Signature page follows]*

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

**WELLMONT HEALTH SYSTEM**

By:   
\_\_\_\_\_  
Roger Leonard  
Chairman of the Board of Directors

  
\_\_\_\_\_  
Bart Hove  
President and Chief Executive Officer

**MOUNTAIN STATES HEALTH ALLIANCE**

By:   
\_\_\_\_\_  
Barbara Allen  
Chairman of the Board of Directors

  
\_\_\_\_\_  
Alan Levine  
President and Chief Executive Officer

**EXHIBITS**

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

**Exhibit F. Integration Council**

**Exhibit H. Cooperative Agreement Terms**

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**EXHIBIT C-2**  
**Interim Directors and Interim Officers**

**Directors:**

Barbara Allen

Roger Leonard

Roger Mowen

Gary Peacock

**Officers:**

President: Alan Levine

Secretary/Treasurer: Bart Hove

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**EXHIBIT F**  
**Integration Council**

**MSHA**

Marvin Eichorn (Co-Chair)  
Dr. Morris Seligman  
Lynn Krutak  
Tony Keck  
Dr. Sandra Brooks  
Tim Belisle

**WHS**

Eric Deaton (Co-Chair)  
Todd Dougan  
Dr. Robert Funke  
Dr. Dale Sargent  
Todd Norris  
Gary Miller

**EXHIBIT H**

**Cooperative Agreement Terms**

Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties do hereby agree upon and incorporate the following terms as part of this Cooperative Agreement:

(e) **REQUEST**: A description of the competitive environment in the parties’ geographic service area, including:

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

**RESPONSE**: The Parties intend for the Cooperative Agreement to include all services, products, and service locations under the control of Mountain States and Wellmont at the time of execution of the Cooperative Agreement and for so long as those entities remain under the control of the New Health System.

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

**RESPONSE**: The Parties estimate their current share in the Geographic Service Area for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data<sup>1</sup> as follows:

**Table 11.1 – Share of CY2014 Discharges, Current Systems<sup>2</sup>**

<b>System</b>	<b>Total</b>	<b>Share of Total Discharges</b>
<b>Mountain States</b>	58,441	45.6%
<b>Wellmont</b>	35,075	27.4%
<b>Other</b>	34,584	27.0%

**Table 11.1** identifies the percentage of total discharges in the Geographic Service Area (exclusive of DRG 795) that are accounted for by Mountain States, Wellmont, or other health care systems. Share analyses demonstrate that three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center, and Johnson City Medical Center) make up fifty-eight percent (58%) of the combined

<sup>1</sup> Shares of the Geographic Service Area and for general acute care inpatient services were calculated using CY2014 discharge data for all Tennessee and Virginia hospitals. Shares were calculated defining general acute care services excluding normal newborns (DRG 795) and including (excluding) MDC 19 (Mental Diseases) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). Tables detailing discharges by hospitals serving the Geographic Service Area, and hospitals in the Geographic Service Area, are in **Exhibit 5.2**.

<sup>2</sup> Shares for this table were calculated defining general acute care services excluding normal newborns (DRG 795).

system's discharges.<sup>3</sup> Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

If the COPA is granted and volumes in the Geographic Service Area remain consistent with CY2014 trends, then the Parties estimate the projected shares for general acute care inpatient services would be as follows in **Table 11.2**:

**Table 11.2 – Share of CY 2014 Discharges, New Health System**

System	Total	Share of Total Discharges
<b>New Health System</b>	93,516	73.0%
<b>Independent Competitors</b>	34,584	27.0%

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 11.3**<sup>4</sup> provides share estimates for independent physicians, Wellmont, and Mountain States in the specialties in which there is an overlap. **Table 11.4** reports shares for specialties in which there is not an overlap – that is, where Mountain States and Wellmont do not each employ physicians.

<sup>3</sup> These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.

<sup>4</sup> **Tables 11.3** and **11.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at their hospitals and employed or affiliated physicians and the specialty of physicians.

Table 11.3 – Shares of Physicians in Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate <sup>5</sup>
<b>Grand Total (Overlap/Non-Overlap)</b>		<b>2,142</b>	<b>70%</b>	<b>9%</b>	<b>17%</b>	<b>4%</b>
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
OB/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

<sup>5</sup> Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate <sup>6</sup>
<b>Grand Total (Overlap/Non-Overlap)</b>		<b>2,142</b>	<b>70%</b>	<b>9%</b>	<b>17%</b>	<b>4%</b>
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

<sup>6</sup> Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System (Continued)

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
<b>Grand Total (Overlap/Non-Overlap)</b>		<b>2,142</b>	<b>70%</b>	<b>9%</b>	<b>17%</b>	<b>4%</b>
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

A large number of independent providers of outpatient services compete in the Geographic Service Area. In many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. **Table 11.5**<sup>7</sup> depicts counts and share numbers for categories of outpatient services based on the affiliation of the providers:

<sup>7</sup> **Table 11.5** depicts the counts and shares for categories of outpatient services and is based on a listing provided by the Parties of outpatient facilities by type including names, locations, and affiliations.

**Table 11.5 - Shares of Outpatient Facilities by System**

Service Type	WHS & MSHS	Mountain	Mountain States- NsCH	Wellmont	Non-Managed Joint	All Other*	Total
	Combined %	States	Affiliate		Venture		
Pharmacy	1.4%	5	0	0	0	349	354
Fitness Center	0.0%	0	0	0	0	98	98
XRAY	28.3%	14	0	12	0	66	92
Nursing Home	7.6%	3	0	2	0	61	66
Physical Therapy	6.6%	1	0	3	0	57	61
Home Health	16.7%	8	0	2	0	50	60
Rehabilitation	39.5%	9	0	8	0	26	43
CT	51.2%	12	0	10	0	21	43
MRI	43.9%	11	0	7	0	23	41
Surgery - Endoscopy	45.2%	9	0	5	0	17	31
Urgent Care	50.0%	8	0	8	0	16	32
Surgery - Hospital-based	46.7%	9	0	5	0	16	30
Dialysis Services	0.0%	0	0	0	0	25	25
Wellness Center	14.3%	2	0	1	0	18	21
Surgery - ASC	60.0%	2	0	3	4	6	15
Chemotherapy	55.6%	4	1	5	0	8	18
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	16
Radiation Therapy	54.5%	3	0	3	0	5	11
Cancer Center	54.5%	3	0	3	0	5	11
Weight Loss Center	14.3%	0	0	1	0	6	7
Community Center	0.0%	0	0	0	0	6	6
Cancer Support Services	0.0%	0	0	0	0	1	1
Women's Cancer Services	100.0%	0	0	1	0	0	1

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

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

**RESPONSE:** The Parties acknowledge that the merger will eliminate competition between Wellmont and Mountain States in certain areas. The benefits of the merger will far outweigh this loss of competition, due to the cost-savings, quality enhancement and improved access the merger will generate. In addition, significant benefits will result from the Parties' commitments outlined herein, all of which will be actively supervised by the States. Moreover, the New Health System will face significant competition from the independent hospitals and other health care providers located in its service area, and, increasingly, from more distantly located health systems. With enhanced access to cost and quality information, patients utilize their mobility and often leave the immediate service area for health care services in locations including Nashville, Asheville, Knoxville and Winston Salem. The parties expect this pattern to increase.

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

**RESPONSE:** No Certificate of Need will be required under the proposed Cooperative Agreement.

- (f) **REQUEST:** Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals.

**RESPONSE:** It is the objective of the New Health System to become one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. In order to achieve this objective, the Parties will conduct frequent employee and physician satisfaction and engagement assessments benchmarking with national organizations to achieve at least top quartile performance. The Parties will also build substantial partnerships beyond what currently exist with regional colleges and universities in Tennessee and Virginia that train physicians, nurses, and allied health professionals to ensure there is a strong pipeline of regional health professionals.

The Parties recognize that their workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for their team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success. The New Health System is committed to its existing workforce. Therefore, when the New Health System is formed:

#### COMMITMENTS

- The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.
- The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.
- The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

The New Health System will achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by volume and varies across the market from time to time. Health care workers are in great demand in the region, and retaining and developing excellent health professionals in the region will be of utmost importance to ensure the highest clinical quality. Wages must remain competitive to attract top regional and national talent.

Further, significant investments must be made in the development of infrastructures and human resources for community health improvement, population health management, academics and research, and new high-level services. In addition to the significant ongoing base of clinical personnel, support staff, and physicians, all of these initiatives will serve to further develop the region's health care workforce and support the regional economy.

A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical center aligned in important ways with the New Health System in its efforts to transform health care delivery and to address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of an enhanced academic medical center to bring specific health care and economic benefits to the community. For example, the Parties, with their academic partners, plan to create new specialty fellowship training opportunities, build an expanded research infrastructure, add new medical and related faculty, and attract research funding, especially translational research, to address regional health improvement objectives. These efforts will benefit the community directly and indirectly, with expanded efforts to develop research specific to the local communities' health care needs and issues. The Parties intend for the enhanced academic medical center to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities with overall health and economic well-being.

In the current environment, Wellmont and Mountain States have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than \$85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, build and sustain research infrastructure, and add faculty. These are all critical to sustaining an

active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists. Specifically, the Parties commit to the following:

COMMITMENTS
<ul style="list-style-type: none"><li>• With academic partners in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.</li><li>• The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.</li></ul>

(g) **REQUEST:** Description of financial performance, including:

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

**RESPONSE:** See attached **Exhibit 11.4** for a description and summary of all aspects of the financial performance of Mountain States for the preceding five fiscal years. See attached **Exhibit 11.5** for a description and summary of all aspects of the financial performance of Wellmont for the preceding five fiscal years. The Mountain States Covenant Compliance Certificates (**Exhibit 11.4D**), the Mountain States Officer's Certificates accompanying Independent Auditor's Reports (**Exhibit 11.4E**), and the Wellmont External Auditor Management Letters (**Exhibit 11.5D**) are considered confidential information and will be subsequently filed.

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

**RESPONSE:** The current annual budgets for Mountain States (Exhibit 11.6) and Wellmont (Exhibit 11.7) are considered competitively sensitive information under federal antitrust laws and will be subsequently filed. A five-year projected budget for the New Health System is attached as Exhibit 11.8.

- (iii) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;
- I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

**RESPONSE:** Please see attached Exhibit 11.9 identifying all insurance contracts and payer agreements in place at the time of the Application for Mountain States. Please see attached Exhibit 11.10 identifying all insurance contracts and payer agreements in place at the time of the Application for Wellmont.

While some of the payer agreements held by both Parties permit the termination of the agreement by the payer upon a change of control, the Parties do not intend to amend their current insurance and payer agreements in connection with completing the affiliation except as set forth herein. Going forward, the Parties intend the New Health System will negotiate with the payers in the ordinary course of business as each managed care contract comes up for renewal after the Closing.

- II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties of the Cooperative Agreement, if the COPA is granted including changes in percentage of risk-bearing contracts;

**RESPONSE:** Like other health systems across Tennessee and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals. Wellmont and Mountain States each approach these negotiations with the basic goal of agreeing on rates and terms that will enable the health systems to cover the cost of providing high quality health care while earning a reasonable margin to invest in maintaining and improving their facilities and expand their service offerings.

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases,

which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

#### COMMITMENTS

- For all Principal Payers,\* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.
- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer\* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

\* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients. Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

The Parties' intend to manage population health through the deployment of a research-based ten year plan that is focused on reducing the variables leading to chronic disease, improved clinical coordination, higher quality facilitated by the consolidation of services, and a shared information technology platform, among other things. All of these benefits strengthen the ability of the Parties to engage in risk-based contracting to a far greater extent than is currently the practice in the region. It is, therefore, the intent of the New Health System that future contractual arrangements with payers will be more focused on identification of the drivers of cost, with a shared objective of reducing unnecessary cost, and sharing the benefit of such successful initiatives.

III. The following policies:

- A. Policy that assures no restrictions to Medicare and/or Medicaid patients,
- B. Policies for free or reduced fee care for the uninsured and indigent,
- C. Policies for bad debt write-off; and
- D. Policies that assure parties to the Cooperative Agreement will maintain or exceed the existing level of charitable programs and services.

**RESPONSE:** Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid are housed within Mountain States. The New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. The current charity and other related policies for both Mountain States and Wellmont are attached as **Exhibits 8.3 and 8.4**. If the COPA is granted, the Parties intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Parties and consistent with the IRS's final 501(r) rules. As evidence of this commitment, the Parties have committed in the Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Parties.<sup>8</sup> Specifically, the Parties intend to address each category of patients as follows:

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<sup>8</sup> See **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.
- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

IV. Identification of existing or future business plans, reports, studies or other documents of each party that:

- A. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and
- B. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.

**RESPONSE:** Information regarding existing and future business plans of Mountain States (**Exhibit 11.11**) and Wellmont (**Exhibit 11.12**) is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

(h) **REQUEST:** A description of the plan to systematically integrate health care and preventive services among the parties to the Cooperative Agreement, in the proposed geographic service area, to address the following:

- (i) A streamlined management structure, including a description of a single board of directors, centralized leadership and operating structure;

**RESPONSE:** Please see response to 11.b above.

- (ii) Alignment of the care delivery decisions of the system with the interest of the community;

**RESPONSE:** A well-executed merger provides multiple opportunities to enhance care delivery and patient outcomes through the consolidation, integration, realignment and/or enhancement of clinical facilities and services (collectively the "Clinical Consolidation"). Clinical Consolidation can involve both concentration of services of a particular type in fewer locations and/or establishment of common protocols and systems across a common set of services with an ultimate goal of yielding improved outcomes, sustaining the most effective levels of services at the right locations, reducing costs of care, and related efficiencies. Where appropriate, these Clinical Consolidations are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered by a health care delivery system are continuously evaluated to ensure efficiency and the best outcome for patients.

As a means to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy that will allow the New Health System to utilize a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients and to make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 11.13**.

A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefit and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as those proposed by the New Health System and outlined in this Application.

(iii) Clinical standardization;

**RESPONSE:** A well-executed merger can also improve patient outcomes if it results in improved performance management processes to assist leaders in identifying where (and why) problems are occurring and how to implement best practices to coordinate care across the system. The New Health System is firmly committed to standardizing its management and clinical practice policies and procedures to promote efficiency and higher standards of care throughout the New Health System. As evidence of this commitment, the New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and financial information needed to integrate this process across the range of inpatient, outpatient, and physician services. The Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in **Section 8** herein. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

(iv) Alignment of cultural identities of the parties to the Cooperative Agreement; and

**RESPONSE:** There are many specific steps the Parties will take to align the cultural identities of the two organizations, including merging the executive leadership, establishing a board made up of equal representation from both legacy systems, agreeing on the appointment of new, independent board members with expertise in integration, implementation of a Clinical Council, bringing together key providers of both systems and implementing a single information technology platform that will be used to promote system-wide communication, cultural integration, and implement common clinical standards for improvement of patient quality.

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The New Health System's board of directors and management team will be composed of current executives from both Wellmont and Mountain States.

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.
- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who would not be incumbent members of either Party's board of directors.
- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU.
- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).
- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

Promptly after Closing, the New Health System will establish a physician-led Clinical Council (see **Section 8.A.iii**) to establish common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States.

As discussed in **Section 8.A.i**, the New Health System will adopt a Common Clinical IT Platform that will allow all providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care.

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer

competitive salaries, and combine the best of each hospital's career development programs as described more fully in **Section 11.f**.

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in **Section 8.A.iv**. This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

- (v) Implementation of risk-based payment models to include risk, a schedule of risk assumption and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

**RESPONSE:** Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients in a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.

The New Health System intends to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period. Additionally, the New Health System will commit to having at least one risk-based model in place within two years after Closing. No payer has historically expressed an interest in a global spending cap for hospital services in this region. However, after completing its clinical integration/alignment, the New Health System is willing to engage in those discussions if requested by a reputable payer, and assuming the New Health System is extended an actuarially sound proposal.

As further evidence of its commitment to move towards risk-based payment, the New Health System is willing to commit to the following:

<b>COMMITMENTS</b>
<ul style="list-style-type: none"><li>• For all Principal Payers,* the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system.</li><li>• Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.</li></ul> <p style="font-size: small;">* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.</p>

(i) **REQUEST:** A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement including:

- Proposed use of any cost savings to reduce prices borne by insurers and consumers;
- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term Population health improvements; and
- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

**RESPONSE:** Funding the population health, access to care, enhanced health services, and other commitments described in this Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Parties have analyzed the anticipated efficiencies in three categories and calculated the following anticipated savings.

The Parties commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies. The economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three

was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are more fully discussed below.

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include
  - Harmonization to a Common Clinical IT platform
  - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
  - Reductions in unnecessary duplication of Call Pay
  - Reductions in Locum Tenens and use of "Registry Staff"
  - Renegotiations of service, maintenance, and other contracts
  - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
  - Added economies and efficiencies gained from the larger size of the New Health System.

The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately \$70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from

the merger in labor expenses totaling approximately \$25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. **Clinical Efficiencies.** The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies

generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately \$26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 11.h.ii, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

- Proposed use of any cost savings to reduce prices borne by insurers and consumers.

RESPONSE: To ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

### COMMITMENTS

- For all Principal Payers,\* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.
- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer\* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

\* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

RESPONSE: The New Health System is committed to improving community health through investment of not less than \$75 million over ten years in science

and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.
- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For

example, the Northeast region<sup>9</sup> ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

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<sup>9</sup> The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. See <https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf> accessed February 4, 2016.

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least \$140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; develop community-based mental health resources such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Improving Health Care Value. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices which are described in more detail in this Application.

Investment in Health Research and Graduate Medical Education. The New Health System will commit not less than \$85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. These funds will enhance the Parties' academic partners' abilities to invest in additional research infrastructure, a significant benefit to the State of Tennessee and Commonwealth of Virginia. Additionally, partnerships with academic institutions in Tennessee and Virginia will enable research-based and academic approaches to the provision of the services the New Health System intends to invest to improve overall population health. These initiatives would not be sustainable in the region without the financial support created by the merger.

Avoidance of Duplication of Hospital Resources. Combining the region's two major health systems in an integrated delivery model is the best and most effective way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. These efforts will provide resources that can be invested in more value-based spending in the region –

spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

Improvements in Patient Outcomes. The region served by the Parties to the Cooperative Agreement faces significant health care challenges. In this environment, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes in the region. The New Health System will adopt a Common Clinical IT Platform to allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide, physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of up to \$150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over \$19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain hospital operations in these areas across the region to preserve and enhance access to quality care in these rural communities.

Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant

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gaps exist in the continuum of care related to these services. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems. The New Health System will invest in the development of new capacity for residential addiction treatment with the goal of reducing the incidence of addiction in our region.

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

**RESPONSE**: The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report finds that all Tennessee counties in the Geographic Service Area exceed the national average for smoking. The state level obesity rate exceeds the national average and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%). According to the same report, three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birth weight births and three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates. **Table 8.1** reports key statistics on the population of the counties in the Geographic Service Area, including metrics for obesity, smoking, death rates due to drug poisoning and childhood poverty.

The Parties share the State's concern about health disparities in the region and are aware of the acute challenges present in the individual counties across the Geographic Service Area. As a result, the Parties propose that ongoing evaluation of the Public Advantage resulting from the merger take into consideration the New Health System's pursuit of the Institute of Health Improvement's Triple Aim goals, commonly considered the national standard for evaluation of health care effectiveness. The Triple Aim objectives are to improve population health, improve patient experience of care (quality and access), and

manage the per capita cost of health care. In this application, the Parties have organized the necessary actions by the New Health System to pursue the Triple Aim objectives as follows:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Research and Graduate Medical Education
- Attracting and Retaining a Strong Workforce

In order to evaluate the public benefit provided by the New Health System on a continuous basis, the Parties propose that the Department adopt an **Index of Public Advantage and Community Health Improvement** comprised of five major categories:

- A. Commitment to Improve Community Health
- B. Enhanced Health Care Services
- C. Expanding Access and Choice
- D. Improving Health Care Value: Managing Quality, Cost and Service
- E. Investment in Health Research/Education and Commitment to Workforce

A description of each category and the accountability mechanisms the Parties propose the State consider for each category are outlined in detail in the following sections.

**A. Commitment to Improve Community Health**

Community health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care. Because of the complex set of influences that shape community health and well-being, effective improvement strategies must be developed through a combination of evidence-based approaches and an understanding of local and regional culture, capacity and resources. Plans that are adopted “off the shelf” from elsewhere, without community buy-in and adaptation, have less chance of success. Although there are similarities with other parts of Tennessee and Virginia, the southern Appalachian mountain region of Northeast Tennessee and Southwest Virginia has a distinct culture, capacity and resource base that results in a unique set of health issues.

There are tremendously valuable assets, organizations and individuals highly motivated to address the underlying factors that affect the poor health status of our region. ETSU's College of Public Health and Quillen College of Medicine are both nationally recognized for their contributions to rural community health improvement, along with a host of other academic institutions throughout the region. In addition, municipalities, community organizations such as local United Way agencies and YMCAs, Healthy Kingsport, chambers of commerce, and health departments are highly motivated to work in new, focused ways to improve community health.

Much of the work and investment devoted to these efforts in the past, however, has

lacked unified focus in combination with sustainable funding. While the Parties believe that motivated leadership and substantial investment from the New Health System will be transformational, they also believe that a sustainable collective impact model of community health improvement stands the best chance of creating long-standing health improvements.

To make sustained improvements in health, a portfolio of investments, interventions and performance improvements designed to impact specific long-term goals at a variety of intervention and prevention levels is necessary. **Figure 11.1** depicts the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") process for community health improvement. MAPP suggests that it is critical for the New Health System, the State and local Departments of Health and the broad community of stakeholders to work together in an Accountable Care Community arrangement to formulate the appropriate investments, interventions and performance improvements to populate a robust and dynamic community health improvement portfolio. This process includes 1) defining a common vision and goals; 2) conducting comprehensive assessments of community health status and well as community and public health systems culture, capacity and resources; 3) prioritizing health issues; 4) formulating goals and strategies; and 5) evaluation and monitoring.

**Figure 11.1 - Mobilizing for Action through Planning and Partnerships**



Some progress has already been made. Several local, state and national analyses have identified the key health issues in our region and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed.

Additionally, in cooperation with the College of Public Health at ETSU, the Parties launched the region’s most substantial community health improvement assessment effort

in August. Four Community Health Work Groups have been created to specifically focus on medical needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. These workgroups are co-chaired by regional community leaders from both Tennessee and Virginia and are organized by Healthy Children and Families, Mental Health and Addiction, Population Health and Healthy Communities, and Research and Academics. The charters for these groups can be found in **Exhibit 8.2A**.

Analyzing the most current findings of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Southwest Virginia Blueprint for Health Improvement and Health-Enabled Prosperity, as well as initial feedback from the Community Health Work Groups organized by Mountain States and Wellmont, the Parties have identified five Key Focus Areas and several related Health Concerns in which the New Health System is committed to investing at least \$75 million over ten years in population health improvement.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.
- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.
- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.
- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.
- ***Improve Access to Behavioral Health Services*** through new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region; as well as community-based mental health resources, such as mental health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.

For the first category of the Index, the Parties propose an accountability mechanism for

the commitment to improve community health that the New Health System has set forth in this Application. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) in **Table 11.6**.

**Table 11.6 - Proposed Commitment to Improve Community Health Measures**

<b>Index of Public Advantage and Community Health Improvement</b>		
<b>A. Commitment to Improve Community Health Measures</b>		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement.	Annual report to State attesting to progress towards compliance until \$75 million is invested.
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed-upon by the State and the New Health System in the COPA.	Commitment to Community Health Annual Report to State will attest to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.

In addition to the Commitment to Community Health Annual Report, described in more detail below, the Parties will submit a yearly report to the State attesting to progress toward the creation of a new integrated delivery system through investment of not less than \$75 million and an annual report to the State attesting to compliance with the quality reporting obligations as outlined in the COPA.

The annual report to the State attesting to progress on the achievement of accountability mechanisms for each Key Focus Area (the "Commitment to Community Health Annual Report") would be developed as follows:

**Proposal for Development of the Commitment to Community Health Annual Report**

- As part of the State's process to determine the Application's completeness, the Department and the Parties will agree on the Key Focus Areas of the commitment to improve community health.
- After the Application is deemed complete, and during the Application review period, the New Health System and the Department, with input from community stakeholders (including the Department's Advisory Groups) will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the State and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the COPA.

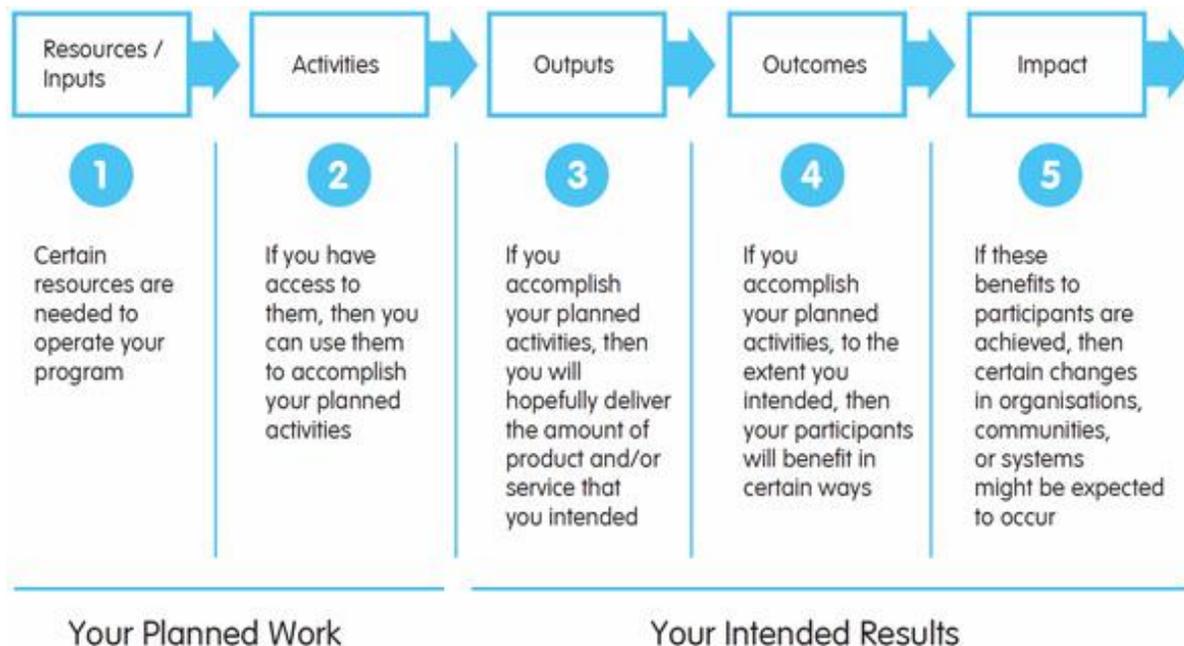
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- The COPA, if granted, will outline the specific Key Focus Areas, the individual Health Concerns, the Accountability Mechanisms, the Tracking Measures, and relevant baselines within each area agreed upon by the Department and the New Health System to be included in the Commitment to Community Health Annual Report.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in **Figure 11.2** for development of the Commitment to Community Health Annual Report Measures.

The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change occurring in organizations, communities or systems as a result of program activities often with longer-term time frames of 7 to 10 years.

**Figure 11.2 - Logic Model for Evaluation**



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Under this model the State could evaluate progress toward *long-term* community health improvement outcomes under the COPA by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The State and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).

**Table 11.7** identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Parties propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Parties have identified specific Health Concerns (first column) that pose an important challenge and priority for health in this region; these are aligned with health challenges and priorities identified by the states. The second column identifies a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally.

Column Three provides a *representative* investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area.

The fourth (highlighted) column provides the relevant Accountability Mechanism the parties believe reflects the New Health System's performance related to the investment, intervention, or performance improvement.

Column Five provides a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern.<sup>10</sup> The final two columns reference County level disparities as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

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<sup>10</sup> In addition to consideration of Triple Aim objectives, the Parties also have considered the categories of health measures for access, cost, health, and quality identified in the Institute of Medicine ("IOM") Vital Signs Core Measures; each of the several areas that these investment, intervention, or performance improvement would target are aligned with specific IOM Core Measures.

**Table 11.7 - Sample Commitment to Community Health Annual Report**

<i>Health Concern</i>	<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area<sup>11</sup></i>	
<b>Key Focus Area #1: Ensure Strong Starts for Children</b>							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties <sup>12</sup>	Establish agreed- upon number of evidence-based Home Visitation Programs <sup>13</sup> in specific counties by set date	Percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs	Johnson, Carter, Cocke <sup>14</sup>	Tazewell, Buchanan, Smyth <sup>15</sup>
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with Neonatal Abstinence Syndrome	Establish residential treatment for pregnant woman with addiction in certain high-risk communities <sup>16</sup>	Establish agreed-upon number of residential treatment programs for pregnant woman with addiction in specific counties by set date	Number of women in high-risk communities initiating residential treatment	Hancock, Hamblen, Hawkins <sup>17</sup>	Dickenson, Wise, Tazewell, Buchanan <sup>18</sup>

<sup>11</sup> This column is based on data that includes the Virginia counties and Independent Cities within the Geographic Service Area.

<sup>12</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,4,5,8, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>13</sup> Nurse Family Partnership is one example of a Department of Health and Human Services “evidenced based early childhood home visitation service delivery model.” Nurse Family Partnership is designed for first-time, low-income mothers and their children, from during pregnancy to when the child turns two. It includes face-to-face home visits by a registered nurse trained in the Nurse Family Partnership fidelity model.

<sup>14</sup> Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

<sup>15</sup> Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

<sup>16</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,4,8,and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>17</sup> As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

<sup>18</sup> As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area<sup>11</sup></i>
3.	Childhood Obesity	Percent children w/ BMI >= 95th percentile of the sex-specific CDC BMI-for-age growth charts	Expand “Morning Mile” Program in certain high-risk communities <sup>19</sup>	Expand “Morning Mile <sup>20</sup> ” Program through investment of an agreed-upon amount by set date	Number of children participating in Morning Mile in high-risk communities	Hawkins, Sullivan, Greene <sup>21</sup>	Russell, Scott, Grayson, Washington, Wise <sup>22</sup>
4.	Third Grade Reading Ability	Percent 3 <sup>rd</sup> graders reading at grade level	Expand “BEAR Buddies” program <sup>23</sup>	Expand “BEAR Buddies <sup>24</sup> ” program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in Tennessee & Virginia in high-risk communities	Hancock, Cocke, Carter <sup>25</sup>	Bristol City, Buchanan, Wythe <sup>26</sup>
<b>Key Focus Area #2: Help Adults Live Well in the Community</b>							

<sup>19</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>20</sup> The Morning Mile is a before-school walking/running program that gives children the chance to start each day in an active way while enjoying fun, music and friends. The Morning Mile is currently sponsored in the Geographic Service Area by Mountain States. Additional Information is *available at*: <https://www.mountainstateshealth.com/medical-services/kohls-morning-mile>

<sup>21</sup> As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Tennessee: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

<sup>22</sup>As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Grayson, Washington, and Wise are in a three-way tie having the third highest obesity rate among the counties in the service region. Virginia: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

<sup>23</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>24</sup> The BEAR (Being Engaged to Achieve Reading) Buddies program is a partnership between Niswonger Children’s Hospital and local schools designed to help children achieve early reading proficiency. BEAR Buddies pairs high school mentors with students in first, second or third grade who are six months or more behind in their reading level.

<sup>25</sup> Tennessee: TCAP District Level Results – 3<sup>rd</sup> through 8<sup>th</sup> Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.

<sup>26</sup> Virginia: SOL Assessment – 3<sup>rd</sup> Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area<sup>11</sup></i>
1.	Premature death from Cardiovascular Disease	Age-Adjusted Death Rates for Diseases of the Heart per 100,000	Expansion of community-based smoking cessation programs in certain high-risk communities <sup>27</sup>	Expansion of community-based smoking cessation programs through investment of an agreed-upon amount by set date	Number of participants in smoking cessation programs in high-risk communities	Unicoi, Cocke, Hancock <sup>28</sup>	Tazewell, Smyth, Scott <sup>29</sup>
2.	Premature death from Diabetes	Age Adjusted Death Rates for Diabetes Mellitus per 100,000	Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications <sup>30</sup>	Establish Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications by set date	Number of Physicians participating in quality improvement project	Hamblen, Carter, Greene, Sullivan <sup>31</sup>	Scott, Smyth, Tazewell
3.	Premature death from Breast, Cervical, Colon and Lung Cancer	Age Adjusted Death Rates for Select Cancers per 100,000	Establish Faith-based screening campaigns for selected cancers (e.g. mammograms, prostate cancer) in specific high-risk counties <sup>32</sup>	Establish agreed-upon number of Faith-based screening campaigns in certain counties by set date	Number of parishioner screenings in high-risk counties	Hawkins, Cocke, Johnson <sup>33</sup>	Bristol City, Smyth, Buchanan <sup>34</sup>
<b>Key Focus Area #3: Promote a Drug-Free Community</b>							

<sup>27</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,7,8,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>28</sup> "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

<sup>29</sup> "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

<sup>30</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,7,8,9,10, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>31</sup> Tennessee: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>. Greene and Sullivan counties tie for having the third highest rate among counties in the service area. Virginia: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. Available at: <http://ahrf.hrsa.gov/>.

<sup>32</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,7,8,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>33</sup> Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.

<sup>34</sup> Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.

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<i>Health Concern</i>		<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area<sup>11</sup></i>
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program <sup>35</sup>	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins <sup>36</sup>	Dickenson, Wise, Tazewell, Buchanan <sup>37</sup>
2.	Tobacco use in Teens	Percent of teens currently smoking	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco in certain high-risk counties <sup>38</sup>	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco through an agreed-upon investment by set date	Number of anti-smoking impressions in high-risk communities	Hancock, Carter, Greene <sup>39</sup>	Wise, Dickenson, Buchanan <sup>40</sup>
<b>Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured</b>							
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers <sup>41</sup>	Establish agreed-upon number of Integrated Care Management Programs for Uninsured Community Super-Utilizers by set date	Number of Uninsured Community Super-Utilizers in Active Care Management	Hancock, Unicoi, Cocke <sup>42</sup>	Buchanan, Russell, Lee <sup>43</sup>

<sup>35</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,8,10,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>36</sup> Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

<sup>37</sup> Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

<sup>38</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 11,2,4,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>39</sup> As county-level data on teen smoking was not available, adult smoking rates were used as a proxy. Tennessee: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

<sup>40</sup> As county-level data on teen smoking was not available, adult smoking rates were used as a proxy measure. Virginia: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

<sup>41</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,6,7,8,9,10,11,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>42</sup> As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Tennessee." County Health Rankings. Accessed February 3, 2016.

<sup>43</sup> As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Virginia." County Health Rankings. Accessed February 3, 2016.

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<i>Health Concern</i>	<i>Health Concern Tracking Measures in the Geographic Service Area</i>	<i>Representative Investment, Intervention, or Performance Improvement</i>	<i>Representative Accountability Measures</i>	<i>Representative Progress Measures</i>	<i>Lowest Ranking Tennessee Counties in Geographic Service Area</i>	<i>Lowest ranking Virginia Counties in Geographic Service Area<sup>11</sup></i>	
<b>Key Focus Area #5: Access to Behavioral Health Services</b>							
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties <sup>44</sup>	Establish an agreed-upon number of Crisis Receiving Centers in specific hospitals by set date	Number of individuals managed in Crisis Receiving Center.	Hancock, Cocke, Hamblen <sup>45</sup>	Wise, Dickenson, Tazewell <sup>46</sup>

**Representative Example:**

If the State and the New Health System agree that one of the Key Focus Areas in the Commitment to Community Health Annual Report should be Ensuring Strong Starts for Children, one health concern the Parties suggest targeting is low birth-weight babies. The baseline for tracking this health concern would be the Low Birth Weight Rate per 100,000 population for specific counties within the Geographic Service Area. One investment, intervention, or performance improvement that the New Health System could undertake to address this health concern would be to establish evidence-based Home Visitation Programs in certain high-risk counties. The Representative Index Measures would reflect the New Health System's commitment to the State to establish an agreed-upon number of evidence-based Home Visitation Programs in certain counties by agreed-upon dates. The Progress Measures that could be used by the State and the New Health System to measure progress in addressing this health concern would be the percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs.

<sup>44</sup> This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3, and 8. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

<sup>45</sup> As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Tennessee: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

<sup>46</sup> As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Virginia: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

**Periodic Review of the Commitment to Community Health Annual Report**

The Parties recognize that population health is dynamic and the health challenges of a region will change over time. The Annual Report established when the COPA is granted should be periodically reviewed and updated to reflect these changes. The Parties propose that the initial Annual Report and its associated plan be established with the issuance of the COPA. On the fifth anniversary of the COPA, the New Health System and the State will evaluate the Annual Report to determine what adjustments, if any, need to be made to plan elements or accountability mechanisms. Once the New Health System and the State have agreed upon these changes, the updated elements of the Annual Report will go into effect on the sixth anniversary of the COPA for a period of five years. The Parties propose that the periodic review of the Annual Report be performed on the same intervals for as long as the COPA remains in effect.

**B. Enhanced Health Care Services Measures**

Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding.

For the second category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. **Table 11.8** below indicates five areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

**Table 11.8 - Proposed Enhanced Health Care Services Measures**

<b>Index of Public Advantage and Community Health Improvement</b>		
<b>B. Enhanced Health Care Services Measures</b>		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities	Annual progress reports and One-time report to State attesting

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	throughout the region.	to the creation of new capacity for residential addiction recovery services when complete.
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients’ homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.

**C. Expanding Access and Choice Measures**

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both. By integrating the two systems, the Parties will help ensure that communities in the Geographic Service Area continue to have access to the care they need close to home and that care options are expanded rather than reduced.

For the third category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to sustain and expand access and choice. **Table 11.9** below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

**Table 11.9 - Proposed Expanding Access and Choice Measures**

<b>Index of Public Advantage and Community Health Improvement</b>		
<b>C. Expanding Access and Choice Measures</b>		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions	Annual report to State attesting to compliance for five years after formation of the New Health System.

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	open.	
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.

**D. Improving Health Care Value: Managing Quality, Cost and Service Measures**

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of health care cost growth for patients, employers and insurers.

As evidence of their commitment to manage quality, cost, and service, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 11.10** below indicates ten areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

**Table 11.10 - Proposed Improving Health Care Value: Managing Quality, Cost and Service Measures**

<b>Index of Public Advantage and Community Health Improvement</b>		
<b>D. Improving Health Care Value: Managing Quality, Cost and Service Measures</b>		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System	Annual report to State attesting to compliance.

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	<p>negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.</p>	
	<p><i>Commitment</i></p>	<p><i>Proposed Accountability Mechanism</i></p>
<p>3.</p>	<p>The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.</p>	<p>Annual report to State attesting to compliance.</p>
<p>4.</p>	<p>The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.</p>	<p>Annual report to State attesting to compliance.</p>
<p>5.</p>	<p>The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.</p>	<p>Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.</p>
<p>6.</p>	<p>The New Health System will participate meaningfully in a health information exchange open to community providers.</p>	<p>Annual report to State attesting to compliance once health information exchange is fully established.</p>
<p>7.</p>	<p>The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.</p>	<p>Annual report to State attesting to measurement of quality measures identified in <b>Section 8(A)(iv)</b> of the COPA Application.</p>
<p>8.</p>	<p>The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.</p>	<p>Annual report to State attesting to compliance.</p>

9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.		

**E. Investment in Health Research/Education and Commitment to Workforce**

A cornerstone of the proposed merger is the expansion of the health-related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Tennessee and Virginia. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, and expanded services and training can also contribute to the economic vitality of the area and the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities both with health and economic well-being.

In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by becoming one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. The workforce is the lifeblood of a health care organization and the competition for the labor force will remain intense, both locally and regionally.

As evidence of their commitments to invest in health research and education and to attract and retain a strong workforce, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to achieve these goals. The table below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) of **Table 11.11** below.

**Table 11.11 - Proposed Investment in Health Education/Research and Commitment to Workforce Measures**

<b>Index of Public Advantage and Community Health Improvement</b>		
<b>E. Investment in Health Education/Research and Commitment to Workforce Measures</b>		
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to State attesting compliance.
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State

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		once complete.
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.
	<i>Commitment</i>	<i>Proposed Accountability Mechanism</i>
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.
6.	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.

**Using the Index**

The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure Public Advantage. To calculate the Overall Achievement Score, the Parties propose that the State assign a "Satisfied" or "Not Satisfied" evaluation to each of the five categories of the Index and that the five categories be given equal weight in the scoring process. The score for each category will be the number of measures within that category successfully satisfied divided by the total number of measures within that category. The five category scores should be combined to determine the "Overall Achievement Score" for each year of active State supervision to ensure Public Advantage.

**Representative Example:**

For each of the five categories, the State would assign a "Satisfied" or "Not Satisfied" evaluation to the individual measures agreed upon by the New Health System and the State in the COPA as demonstrated in **Table 11.12** below. If the Parties agreed upon the following Index of Public Advantage and Community Health Improvement, the state would evaluate each individual accountability mechanism as follows:

**Table 11.12 - Demonstration of Evaluation**

	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
<b>A. Commitment to Improve Community Health</b>			
1.	The New Health System is committed to creating a new integrated delivery system designed to improve	Annual report to State attesting to progress towards compliance	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	community health through investment of not less than \$75 million over ten years in population health improvement.	until \$75 million is invested.	
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the COPA.	Annual report to State attesting to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.	Satisfied
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.	Satisfied
<b>B. Enhanced Health Care Services Measures</b>			
1.	The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until \$140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children’s Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.	Satisfied
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients’ homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.	Satisfied
<b>C. Expanding Access and Choice</b>			
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the	Annual report to State attesting to compliance for five years after formation of the New Health System.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.		
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.	Satisfied
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.	Satisfied
5.	Independent physicians will not be required to practice exclusively at the New Health System’s hospitals and other facilities.	Annual report to State attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.	Satisfied
<b>D. Improving Health Care Value: Managing Quality, Cost and Service</b>			
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.	Satisfied
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing	Annual report to State attesting to compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System’s control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.		
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to State attesting to compliance.	Satisfied
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to State attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.	Satisfied
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in <b>Section 8(A)(iv)</b> of the COPA Application.	Satisfied
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.	Annual report to State attesting to compliance.	Satisfied
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.	Satisfied
10.	The New Health System will not engage in “most favored nation” pricing with any health plans.	Annual report to State attesting to compliance.	Satisfied
<b>E. Investment in Health Education/Research and Commitment to Workforce</b>			
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training	Annual report to State attesting compliance.	Satisfied

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	<i>Index of Public Advantage and Community Health Improvement Commitment</i>	<i>Accountability Mechanism</i>	<i>Satisfied or Not Satisfied?</i>
	slots, create new specialty fellowship training opportunities, and add faculty.		
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.	Satisfied
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.			

In this representative example, the Overall Achievement Score would be calculated as demonstrated in **Table 11.13** below:

**Table 11.13 - Demonstration of Overall Achievement Scoring**

<b>Category</b>	<b>Measures Satisfied</b>	<b>Overall Achievement Score</b>
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	6/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
<b>Overall Achievement Score</b>	<b>30/30</b>	<b>100%</b>

**Continuing Public Advantage**

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered clear and convincing evidence of the Public Advantage and the COPA shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered clear and convincing

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evidence of the Public Advantage depending upon the relative circumstances, and the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered evidence, when considering the relative circumstances, that the Public Advantage of the COPA is no longer evident and the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification.

Due to the new and untested nature of the Index of Public Advantage and Community Health Improvement and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether the evidence of the Public Advantage is clear and convincing. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Index of Public Advantage and Community Health Improvement. Further, the Commissioner shall have discretion to determine that the clear and convincing standard has been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

**Representative Examples:**

Example 1. If the New Health System was able to satisfy most of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.14**:

**Table 11.14 - Sample Scoring for Example 1**

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	5/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	9/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
<b>Overall Achievement Score</b>	<b>28/30</b>	<b>93.3%</b>

An Overall Achievement Score of 93.3% is considered clear and convincing evidence of the Public Advantage and the COPA would continue in effect.

Example 2. If the New Health System was not able to satisfy some of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.15**:

**Table 11.15 - Sample Scoring of Example 2**

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	

D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
<b>Overall Achievement Score</b>	<b>19/30</b>	<b>63.3%</b>

An Overall Achievement Score of 63.3% may be considered clear and convincing evidence of the Public Advantage, depending upon the relative circumstances considered by the Commissioner. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information in deciding whether to exercise his or her discretion in seeking a modification to the Cooperative Agreement. After considering the Public Advantage and the explanations for why any Measure has not been satisfied, the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA.

Example 3. If the New Health System was not able to satisfy several Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.16**:

**Table 11.16 - Sample Scoring of Example 3**

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	2/5	
C. Expanding Access and Choice	3/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	5/10	
E. Investment in Health Research/Education and Commitment to Workforce	2/6	
<b>Overall Achievement Score</b>	<b>14/30</b>	<b>46.7%</b>

An Overall Achievement Score of 46.7% may be considered evidence, depending on the relative circumstances, that the Public Advantage of the COPA is no longer evident. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information. The Commissioner would allow a reasonable period of time for a remediation plan to be developed, presented, accepted and implemented for re-evaluation. After considering the Public Advantage, the explanations for why any Measure has not been satisfied, and performance under the remediation plan, the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification. In deciding whether to take action to terminate the COPA under the terms of the certification, the Commissioner would have the authority to consider important public benefits that contribute to the Public Advantage even if those public benefits are not explicitly addressed in the Index of Public Advantage and Community Health Improvement.

### **Index of Public Advantage and Community Health Improvement Conclusion**

The Parties believe that this Index of Public Advantage and Community Health Improvement proposal outlines a process for the New Health System to align its resources and commitments with the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of

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health care in the region. At the same time, the Parties believe that including the Department, the local departments of health, the Community Health Work Groups, the Advisory Groups, and other community stakeholders in finalizing these proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Ultimately, the Parties hope that this process will result in the highest chance of success for improving population health across our region.

### Exhibits and Attachments

<b>Exhibit Number</b>	<b>Description</b>
Exhibit 11.4	Financial Summary for Mountain States
Exhibit 11.4 - Attachment A	Mountain States Bonds Official Statement for 2011 bonds
Exhibit 11.4 - Attachment B	Mountain States Bonds Official Statement for 2012 bonds
Exhibit 11.4 - Attachment C	Mountain States Bonds Official Statement for 2013 bonds
Exhibit 11.4 - Attachment D	Mountain States Covenant Compliance Certificates for the Last Five Years
Exhibit 11.4 - Attachment E	Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14
Exhibit 11.4 - Attachment F	Mountain States Audited Financial Statements for 2009 to 2014
Exhibit 11.4 - Attachment G	Mountain States EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
Exhibit 11.4 - Attachment H	Mountain States - Rating Agencies
Exhibit 11.5	Financial Summary for Wellmont
Exhibit 11.5 - Attachment A	Wellmont 2011 Bonds Official Statement for 2011 bonds
Exhibit 11.5 - Attachment B	Wellmont Audits – External Audited Financial Statements for 2011 to 2014
Exhibit 11.5 - Attachment C	Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
Exhibit 11.5 - Attachment D	Wellmont External Auditor Management Letters for 2011 to 2014
Exhibit 11.5 - Attachment E	Rating Agencies – Fitch and Standard & Poor's Reports
Exhibit 11.6	Current Annual Budgets for Mountain States
Exhibit 11.7	Current Annual Budgets for Wellmont
Exhibit 11.8	Five Year Projected Budget for New Health System
Exhibit 11.9	Mountain States Insurance Contracts and Payer Agreements
Exhibit 11.10	Wellmont Insurance Contracts and Payer Agreements
Exhibit 11.11	Existing and Future Business Plans of Mountain States
Exhibit 11.12	Existing and Future Business Plans of Wellmont
Exhibit 11.13	Alignment Policy
Exhibit 11.14	Institute of Medicine Vital Signs Core Measures

## APPENDIX I

**17. Fairness Opinions. Attach as Appendix I any and all fairness opinions analyzing the Transaction along with any supplemental analyses prepared by the Public Benefit Hospital or its Experts. Include in your response the name of the company and the person(s) who prepared the opinion, their business telephone numbers and addresses, the agreement or engagement letter with such company or person, and background information regarding the company or person's qualifications.**

None. Mountain States Health Alliance has not obtained a fairness opinion analyzing the Transaction. As explained more fully in Appendix C, because the Transaction is being structured as a combination of two entities and will not involve a sale of assets, transfer of consideration or the payment of a purchase price between the parties, there has not been occasion for a fairness opinion analyzing whether an amount or type of consideration to be received is fair to interested parties in the Transaction.

Mountain States Health Alliance did review and consider numerous reports and analyses regarding the projected financial and business operations of a combined hospital system and the identification and likelihood of potential savings and efficiencies that would result from the Transaction, including the economies and efficiencies analysis performed by FTI Consulting, Inc.

**APPENDIX J**

**18. Meeting Minutes and Other Information. Attach as Appendix J the following documents with respect to each meeting, whether regular, special, or otherwise, of the board of directors or board of trustees for the Public Benefit Hospital:**

- a. Announcements and the persons to whom the announcements were sent;**
- b. Agenda;**
- c. Minutes and/or resolutions of the board of directors or board of trustees for each of the Public Benefit Hospital and the Acquirer which reflect or discuss the Transaction, including**
- d. Each written report or document provided to the board or board members, including, but not limited to, each committee report and each Expert's report;**
- e. Each proposal or document referencing or regarding possible or actual sale, merger, acquisition, dissolution, or distribution of assets of the Public Benefit Hospital;**
- f. Each presentation to the board or any committee to the board; and**
- g. Each attachment to (a) through (f).**

Documents provided as part of Appendix J are organized by organizational body and meeting date. This applies both to the list of Documents below and each Document's location within the electronic submission. Where excerpts of minutes and materials are provided, such excerpts represent the portions of the minutes or material related to the Transaction.

MSHA will provide documents related to the Transaction from meetings of its board of directors, executive committee, and finance committee. Other board committees also received periodic oral briefings on the status of the Transaction but did not receive written reports. MSHA will provide copies of agendas and minutes for those meetings upon request.

Index

**[\*\*\*Following Attachments are Confidential\*\*\*]**

**I. Mountain States Health Alliance Board of Directors**

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## **II. Executive Committee, Mountain States Health Alliance Board of Directors**

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**III. Finance Committee, Mountain States Health Alliance Board of Directors**

**IV. Joint Board Task Force**

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## **V. Integration Council**

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**\*\*\*End of Confidential Attachments\*\*\***

## APPENDIX K

**19. Valuation Information. Attach as Appendix K each appraisal (with each attachment), evaluation (with each attachment), and similar document (with each attachment) concerning the valuation during the last three (3) fiscal years of the Public Benefit Hospital, its assets, its properties, their worth as a going concern, their fair market value, or their price for sale. Explain how the Public Benefit Hospital determined that the Transaction represents fair market value for the assets of the Public Benefit Hospital.**

**This Request shall include, but not be limited to, any appraisals of the common stock of any for-profit subsidiaries of the Public Benefit Hospital, any appraisals of the value of any for-profit subsidiaries of the Public Benefit Hospital, and any real estate appraisals involving property held by the Public Benefit Hospital.**

There have been no appraisals or similar evaluations concerning the valuation of the assets of Mountain States Health Alliance during the last three fiscal years other than for routine financial statement and reporting purposes. Please see the financial statements for Mountain States Health Alliance included in Appendix O. Because the assets are not being sold but will continue to be used by Mountain States for its charitable purposes, this question is not applicable to the Transaction.

**APPENDIX L**

20. **Information Regarding Other Offers.** Attach as Appendix L minutes, reports, letters, memoranda, and other documents (and attachments to each) concerning any negotiation, proposal, or sale either initiated or received by the Public Benefit Hospital regarding a sale of all or substantially all of its assets, a merger, a joint venture, a combination, an arrangement, a partnership, an acquisition, an alliance, an affiliation, or a networking relationship, and the dollar value of each such Transaction.

**\*\*\*Following Materials are Confidential\*\*\***

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**\*\*\*End of Confidential Materials\*\*\***

## **APPENDIX M**

**21. Mission Statement. Attach as Appendix M any and all mission statements of the Public Benefit Hospital.**

### **Mission**

Mountain States Health Alliance is committed to Bringing Loving Care to Healthcare. We exist to identify and respond to the healthcare needs of individuals and communities in our region and to assist them in attaining their highest possible level of health.

### **Vision**

We passionately pursue healing of the mind, body and spirit as we create a world-class healthcare system.

### **Values**

Integrity: Honesty in everything we do

Service: With caring and compassion

Leadership: With creativity and innovation

Excellence: Always pursuing a higher standard

### **Mountain States Philosophy**

Mountain States team members as caregivers create relationships, environments and service delivery centered on the patient through a holistic approach to healing that ministers to the mind, body and spirit. Mountain States caregivers believe that healing can exist without curing, but healing cannot exist without caring.

<https://www.mountainstateshealth.com/about-us/mission-vision-and-values>